

Kaiser Permanente **CHILD HEALTH PLAN**

Individual Plan Membership Agreement and Disclosure Form and Evidence of Coverage

April 1, 2012, through March 31, 2013

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

A nonprofit organization

Notice of availability of language assistance

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）。

2012 Summary of Changes and Clarifications

The following is a summary of the most important changes and clarifications that we have made to this 2012 Child health Plan *Membership Agreement and Evidence of Coverage*. The changes are effective April 1, 2012, unless noted otherwise. Please read this *Membership Agreement and Evidence of Coverage* for the complete text of these changes, as well as minor clarifications not listed in the summary below.

Changes

Notice of changes to coverage and Premiums

Effective January 1, 2011, in response to Senate Bill 1163, we will give 60 days prior written notice of changes that take effect upon renewal or amendment.

Notice of termination of coverage (pending regulatory approval)

Effective January 1, 2011, in response to Assembly Bill 2470, we will provide 30 days prior written notice to the Subscriber of termination under "Termination for Nonpayment" in the "Termination of Agreement" section.

Preventive Services

We have moved the definition of "Preventive Care Services" to the "Definitions" section. Previously, Preventive Care Services were defined in the "Preventive Care Services" section. Also, we have clarified that the Cost Sharing for Preventive Care Services in the "Benefits and Cost Sharing" section applies when the services meet this definition of Preventive Care Services.

Eyeglasses and contact lenses

Eyeglass lenses and most contact lenses are covered as described in the "Vision Service" section at Plan Medical Offices or Plan Optical Sales Offices when prescribed by *any physician or optometrist*. Previously, lenses must be prescribed by a Plan Physician or Plan Optometrist. A prescription from a Plan Physician or Plan Optometrist is required for special contact lenses to treat aphakia and aniridia, and for special contact lenses that provide a significant vision improvement not obtainable with eyeglasses.

Clarifications

Benefit Highlights

We have made the following changes to the benefit highlights in the beginning of the *Disclosure Form and Evidence of Coverage* for clarity:

- We have added a disclosure of the cost Sharing for external prosthetic devices, orthotic devices, and ostomy and urological supplies

- We have clarified that service provided during an office visit may include treatment as well as consultations and exams
- We have standardized the terminology we use to describe group and individual mental health and chemical dependency visits

Ambulance Services (pending regulatory approval)

We have revised the description of coverage for emergency ambulance Services as follows:

We cover Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- A reasonable person would have believed that the medical condition was an Emergency Medical Condition which required ambulance Services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

Applicant

We have revised the definition of “Applicant” to clarify that the Applicant must be a parent or legal guardian.

Applicant: A person age 19 or older who is the parent or legal guardian who applies for coverage under the Child Health Plan on behalf of a child.

Binding arbitration

We have added the following to the “Binding Arbitration” section:

In accord with the rule that applies under Section 3 and 4 of the Federal Arbitration Act, the right to arbitration under this “Binding Arbitration” section shall not be denied, stayed, or otherwise impeded because a dispute between a Member party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting ruling or findings.

Mental Health Care Services

We have added in the "Mental Health Care Services" section the following example of mental health care services that are not covered:

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

Receiving a bill

In the "Cost Sharing" section, we have added the following examples of when a Member may receive a bill:

Receiving a bill. In most cases, we will ask you to make a payment toward your Cost Sharing at the time you check in. Keep in mind that this payment may cover only a portion of the total Cost Sharing for the covered Services you receive, and we will bill you for any additional Cost Sharing amounts that are due. The following are examples of when you may get a bill:

- You receive Services during your visit that were not scheduled when you made your payment at check-in. For example, if you are scheduled to receive treatment for an existing condition, at check-in we will ask you to pay the Cost Sharing that applies to these Services. If during your visit your provider finds another problem with your health, your provider may perform or order additional unscheduled Services to diagnose your problem. You may have to pay separate Cost Sharing amounts for each of these additional unscheduled Services, in addition to the Cost Sharing amount you paid at check-in for the treatment of your existing condition.
- You receive Services from a second provider during your visit that were not scheduled when you made your payment at check-in. For example, if you are scheduled to receive a diagnostic exam, at check-in we will ask you to pay the Cost Sharing that applies to these Services. If during your diagnostic exam your provider confirms a problem with your health, your provider may request the assistance of another provider to perform additional unscheduled Services (such as an outpatient procedure). You may have to pay separate Cost Sharing amounts for the unscheduled Services of the second provider, in addition to the Cost Sharing amount you paid at check-in for your diagnostic exam.
- You go in for Preventive Care Services and receive non-preventive Services during your visit that were not scheduled when you made your payment at check-in. For example, if you go in for a routine physical maintenance exam, at check-in we will ask you to pay the Cost Sharing that applies to these Services (the Cost Sharing may be "no charge"). If during your routine physical maintenance exam your provider finds a problem with your health, your provider may order non-preventive Services to diagnose your problem (such as laboratory tests). You may have to pay separate Cost Sharing amounts for the non-preventive Services performed to diagnose your problem, in addition to the Cost Sharing amount you paid at check-in for your routine physical maintenance exam.
- You request at check-in that we bill you for some or all of the Cost Sharing for the Services you will receive, and we agree to bill you

In some cases, we will not ask you to make a payment at check-in, and we will bill you for any Cost Sharing. For example, some Laboratory Departments do not collect payments at check-in, and we will instead bill you for any Cost Sharing.

Service Area

We have revised the definition of "Service Area" for clarity. The ZIP codes that are in the Service Area for each county are now listed, even when the entire county is inside the Service Area. For each county, we now say whether all ZIP codes in the county are inside the Service Area or whether only the ZIP codes that are listed are inside the Service Area.

TABLE OF CONTENTS

Health Plan Benefits and Coverage Matrix.....	1
Introduction.....	3
About Kaiser Permanente	4
Definitions.....	4
Premiums, Eligibility, and Enrollment.....	11
Premiums	11
Who Is Eligible	12
How to Enroll.....	14
How to Obtain Services	15
Routine Care	16
Urgent Care.....	16
Not Sure What Kind of Care You Need?	16
Your Personal Plan Physician.....	16
Getting a Referral.....	17
Second Opinions.....	19
Contracts with Plan Providers.....	20
Visiting Other Regions	21
Your ID Card	21
Getting Assistance	22
Plan Facilities.....	22
Plan Hospitals and Plan Medical Offices	23
<i>Your Guidebook to Kaiser Permanente Services (Your Guidebook)</i>	28
Emergency Services and Urgent Care.....	28
Emergency Services.....	28
Urgent Care.....	30
Payment and Reimbursement	31
Benefits and Cost Sharing.....	32
Cost Sharing.....	33
Preventive Care Services	35
Outpatient Care	36
Hospital Inpatient Care	37
Ambulance Services	38
Bariatric Surgery.....	39
Chemical Dependency Services.....	40
Dental and Orthodontic Services	41
Dialysis Care.....	42
Durable Medical Equipment for Home Use	43
Health Education.....	44
Hearing Services.....	45
Home Health Care	45

Hospice Care.....	46
Mental Health Services.....	47
Ostomy and Urological Supplies.....	49
Outpatient Imaging, Laboratory, and Special Procedures.....	50
Outpatient Prescription Drugs, Supplies, and Supplements.....	51
Prosthetic and Orthotic Devices.....	53
Reconstructive Surgery.....	55
Services Associated with Clinical Trials.....	55
Skilled Nursing Facility Care.....	56
Transplant Services.....	56
Vision Services.....	57
Exclusions, Limitations, and Reductions.....	59
Exclusions.....	59
Limitations.....	62
Reductions.....	63
Dispute Resolution.....	64
Grievances.....	64
Supporting Documents.....	66
Who May File.....	66
Department of Managed Health Care Complaints.....	67
Independent Medical Review (IMR).....	67
Binding Arbitration.....	69
Termination of Membership.....	72
How You May Terminate Your Membership.....	72
Termination Due to Loss of Eligibility.....	72
Termination for Cause.....	72
Termination for Nonpayment.....	73
Termination for nonpayment of Premiums.....	73
Termination for Discontinuance of a Product.....	74
Payments after Termination.....	74
State Review of Membership Termination.....	74
Conversion to another Individual Plan.....	74
Miscellaneous Provisions.....	75
Helpful Information.....	78
Your Guidebook to <i>Kaiser Permanente Services (Your Guidebook)</i>	78
How to Reach Us.....	78
Payment Responsibility.....	79

Health Plan Benefits and Coverage Matrix

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

Annual Out-of-Pocket Maximum for Certain Services	
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).....	\$250 per calendar year
For any one Member in a Family of two or more Members.....	\$250 per calendar year
For an entire Family of two or more Members.....	\$500 per calendar year
Deductible or Lifetime Maximum	None
Professional Services (Plan Provider office visits)	You Pay
Most primary and specialty care consultations, exams, and treatment.....	\$5 per visit
Routine physical maintenance exams.....	No charge
Well-child preventive exams (through age 23 months).....	No charge
Family planning counseling.....	No charge
Scheduled prenatal care exams and first postpartum follow-up consultation and exam.....	No charge
Eye exams for refraction.....	No charge
Hearing exams.....	No charge
Urgent care consultations, exams, and treatment.....	\$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 injections (including allergy serum).....	\$3 per visit
Most immunizations (including the vaccine).....	No charge
Most X-rays and laboratory tests.....	No charge
Health education:	
Covered individual health education counseling.....	No charge
Covered health education programs.....	No charge
Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.....	No charge
Emergency Health Coverage	You Pay
Emergency Department visits.....	\$35 per visit
Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).	
Ambulance Services	You Pay
Ambulance Services.....	No charge

Prescription Drug Coverage	You Pay
Most covered outpatient items in accord with our drug formulary guidelines at Plan Pharmacies or through our mail-order service ..	\$5 for up to a 100-day supply
Durable Medical Equipment	You Pay
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	No charge
Mental Health Services	You Pay
Inpatient psychiatric hospitalization (up to 30 days per calendar year).....	No charge
Outpatient mental health evaluation and treatment:	
Up to a total of 20 individual and group visits per calendar year that include Services for mental health evaluation or treatment	\$5 per individual visit \$2 per group visit
Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	\$2 per visit
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the "Benefits and Cost Sharing" section.	
Chemical Dependency Services	You Pay
Inpatient detoxification.....	No charge
Individual outpatient chemical dependency evaluation and treatment	\$5 per visit
Group outpatient chemical dependency treatment	\$2 per visit
Transitional residential recovery Services (up to 60 days per contract year, not to exceed 120 days in any five-year period)	No charge
Home Health Services	You Pay
Home health care.....	No charge
Other	You Pay
Eyewear purchased at Plan Medical Offices or Plan Optical Sales Offices every 24 months.....	Amount in excess of \$125 Allowance
Hearing aid(s) every 36 months	Amount in excess of \$1,000 Allowance per aid
Skilled Nursing Facility care (up to 100 days per contract year)	No charge
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	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, and Reductions" sections.

Introduction

This *Child Health Plan Membership Agreement and Disclosure Form and Evidence of Coverage (Membership Agreement and Evidence of Coverage)* describes the health care coverage of “Kaiser Permanente Child Health Plan”. This *Membership Agreement and Evidence of Coverage*, and the Rate Sheet which is incorporated into this agreement by reference, and any amendments to either of them, constitute the legally binding contract between Health Plan (Kaiser Foundation Health Plan, Inc.) and you, the Applicant of an eligible and enrolled child (Member). For benefits provided under any other Health Plan program, refer to that plan’s evidence of coverage.

In this *Membership Agreement and Evidence of Coverage*, Health Plan is sometimes referred to as “we” or “us”. The enrolled child is referred to as “Member”. The Applicant is referred to as “you, your or persons”. Some capitalized terms have special meaning in this *Membership Agreement and Evidence of Coverage*; please see the “Definitions” section for terms you should know.

When joining Kaiser Permanente, the Member is enrolling in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), which we call the “Home Region.” The Service Area of each Region is described in the “Definitions” section of this *Membership Agreement and Evidence of Coverage*. The coverage information in this *Membership Agreement and Evidence of Coverage* applies when obtaining care in the Member’s Home Region. When visiting the other California Region, the Member may receive care as

described in “Visiting Other Regions” in the “How to Obtain Services” section.

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

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

Term of this *Membership Agreement and Evidence of Coverage*

This *Membership Agreement and Evidence of Coverage* is effective from April 1, 2012 (or on the membership effective date in the Applicant’s acceptance letter, if later) through March 31, 2013, unless this Agreement is:

- Revised under “Amendment of Agreement” below
- Terminated under the “Termination of Membership” section
- There are no longer any Members in your Family who are covered under this *Agreement*

Renewal

If you comply with all of the terms of this *Membership Agreement and Evidence of Coverage*, we will offer to renew this *Membership Agreement and Evidence of Coverage* effective April 1, 2013, upon 60 days prior written notice to the Applicant. We will either send the Applicant a new agreement to become effective immediately after termination of this *Membership Agreement and Evidence of Coverage*, or we will extend the term of this *Membership Agreement and Evidence of Coverage* pursuant to “Amendment of

Membership Agreement and Evidence of Coverage." The new or extended agreement will include a new term of agreement and other changes. If you do not want to renew this *Membership Agreement and Evidence of Coverage*, you must give us written notice as described under "How You May Terminate Your Membership" in the "Termination of Membership" section.

Amendment of *Membership Agreement and Evidence of Coverage*

We may amend this *Membership Agreement and Evidence of Coverage* (including Premiums and benefits) at any time by sending written notice to the Applicant at least 30 days before the effective date of the amendment. All such amendments are deemed accepted by the Applicant unless the Applicant gives us written notice of nonacceptance within 60 days of the date of the notice, in which case this *Membership Agreement and Evidence of Coverage* terminates the day before the effective date of the amendment.

If we notified the Applicant that we have not received all necessary governmental approvals related to this *Membership Agreement and Evidence of Coverage*, we may amend this *Membership Agreement and Evidence of Coverage* by giving written notice to the Applicant after receiving all necessary governmental approval. Any such government-approved provisions go into effect on April 1, 2012 (unless the government requires a later effective date).

About Kaiser Permanente

Kaiser Permanente provides Services directly to our Members through an

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

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

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

Definitions

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

section have special meaning when capitalized and used in any section of this *Membership Agreement and Evidence of Coverage*.

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

Applicant: A person age 19 or older who is the parent or legal guardian who applies for coverage under the Child Health Plan on behalf of a child.

Charges: "Charges" means the following:

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

- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts Cost Sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract Cost Sharing

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

Copayment: A specific dollar amount that you must pay when the Member receives 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.

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

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

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

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

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

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

Family: All enrolled Members under the same family account.

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

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

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

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

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat a Member's condition or clinical symptoms in accord with generally

accepted professional standards of practice that are consistent with a standard of care in the medical community.

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

Member: A child from birth through age 18 who is eligible and enrolled under this *Membership Agreement and Evidence of Coverage*, and for whom we have received applicable Premiums. The Applicant is not a Member.

Membership Agreement and Evidence of Coverage: This *Membership Agreement and Evidence of Coverage* document, which describes a Member's Health Plan coverage. This *Membership Agreement*, and any amendments, constitutes the legally binding contract between Health Plan and the Member.

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 the Member's (or the Member's 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:

- Member is temporarily outside their Home Region Service Area

- Member reasonably believes that their (or their unborn child's) health would seriously deteriorate if they delayed treatment until they returned to their Home Region Service Area

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

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

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

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

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

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

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

Post-Stabilization Care: Medically Necessary Services related to a Member's Emergency Medical Condition that they receive after their treating physician determines that this condition is Stabilized.

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

Preventive Care Services: Services that do one or more of the following:

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

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the

Medical Group designates as Primary Care Physicians. Please refer to our website at **kp.org** for a directory of Primary Care Physicians, except that the directory is subject to change without notice. For the current list of physicians that are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook*.

Rate Sheet: The document also known as the Eligibility Guidelines Flyer that list premiums for Kaiser Permanente Child Health Plan.

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 Northern and Southern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington, please call our Member Service Call Center.

Service Area: Health Plan has two Regions in California: the Northern California Region and the Southern California Region. As a Member enrolled under the Kaiser Permanente Individuals and Families, they are enrolled in one of the two California Regions. This *Membership Agreement and Evidence of Coverage* describes the coverage for both California Regions.

Northern California Region Service Area

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

- All ZIP codes in Alameda County are inside our Northern California Service Area: 94501–02, 94514, 94536–46, 94550–52, 94555, 94557, 94560, 94566, 94568, 94577–80, 94586–88, 94601–15, 94617–21, 94622–24, 94649, 94659–62,

94666, 94701–10, 94712, 94720, 95377, 95391

- The following ZIP codes in Amador County are inside our Northern California Service Area: 95640, 95669
- All ZIP codes in Contra Costa County are inside our Northern California Service Area: 94505–07, 94509, 94511, 94513–14, 94516–31, 94547–49, 94551, 94553, 94556, 94561, 94563–65, 94569–70, 94572, 94575, 94582–83, 94595–98, 94706–08, 94801–08, 94820, 94850
- The following ZIP codes in El Dorado County are inside our Northern California Service Area: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in Fresno County are inside our Northern California Service Area: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93737, 93740–41, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93786, 93790–94, 93844, 93888
- The following ZIP codes in Kings County are inside our Northern California Service Area: 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in Madera County are inside our Northern California Service Area: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- All ZIP codes in Marin County are inside our Northern California Service Area: 94901, 94903–04, 94912–15, 94920, 94924–25, 94929–30, 94933, 94937–42, 94945–50, 94956–57, 94960, 94963–66, 94970–71, 94973–74, 94976–79
- The following ZIP codes in Mariposa County are inside our Northern California Service Area: 93601, 93623, 93653
- The following ZIP codes in Napa County are inside our Northern California Service Area: 94503, 94508, 94515, 94558–59, 94562,

- 94567 (except that Knoxville is not in our Northern California Service Area), 94573–74, 94576, 94581, 94589–90, 94599, 95476
- The following ZIP codes in Placer County are inside our Northern California Service Area: 95602–04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95692, 95703, 95722, 95736, 95746–47, 95765
 - All ZIP codes in Sacramento County are inside our Northern California Service Area: 94203–09, 94211, 94229–30, 94232, 94234–37, 94239–40, 94244, 94246–50, 94252, 94254, 94256–59, 94261–63, 94267–69, 94271, 94273–74, 94277, 94279–80, 94282–91, 94293–98, 94571, 95608–11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638–41, 95652, 95655, 95660, 95662, 95670–71, 95673, 95680, 95683, 95690, 95693, 95741–42, 95757–59, 95763, 95811–38, 95840–43, 95851–53, 95860, 95864–67, 95894, 95899
 - All ZIP codes in San Francisco County are inside our Northern California Service Area: 94102–05, 94107–12, 94114–27, 94129–34, 94137, 94139–47, 94151, 94156, 94158–64, 94172, 94177, 94188
 - All ZIP codes in San Joaquin County are inside our Northern California Service Area: 94514, 95201–13, 95215, 95219–20, 95227, 95230–31, 95234, 95236–37, 95240–42, 95253, 95258, 95267, 95269, 95296–97, 95304, 95320, 95330, 95336–37, 95361, 95366, 95376–78, 95385, 95391, 95632, 95686, 95690
 - All ZIP codes in San Mateo County are inside our Northern California Service Area: 94002, 94005, 94010–11, 94014–21, 94025–28, 94030, 94037–38, 94044, 94060–66, 94070, 94074, 94080, 94083, 94128, 94303, 94401–04, 94497
 - The following ZIP codes in Santa Clara County are inside our Northern California Service Area: 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, 95196
 - All ZIP codes in Solano County are inside our Northern California Service Area: 94510, 94512, 94533–35, 94571, 94585, 94589–92, 95616, 95620, 95625, 95687–88, 95690, 95694, 95696
 - The following ZIP codes in Sonoma County are inside our Northern California Service Area: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492
 - All ZIP codes in Stanislaus County are inside our Northern California Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322–23, 95326, 95328–29, 95350–58, 95360–61, 95363, 95367–68, 95380–82, 95385–87, 95397
 - The following ZIP codes in Sutter County are inside our Northern California Service Area: 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95836–37
 - The following ZIP codes in Tulare County are inside our Northern California Service Area: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
 - The following ZIP codes in Yolo County are inside our Northern California Service Area: 95605, 95607, 95612, 95616–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99

- The following ZIP codes in Yuba County are inside our Northern California Service Area: 95692, 95903, 95961

Southern California Region Service Area

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

- The following ZIP codes in Imperial County are inside our Southern California Service Area: 92274–75
- The following ZIP codes in Kern County are inside our Southern California Service Area: 93203, 93205–06, 93215–16, 93220, 93222, 93224–26, 93238, 93240–41, 93243, 93249–52, 93263, 93268, 93276, 93280, 93285, 93287, 93301–09, 93311–14, 93380, 93383–90, 93501–02, 93504–05, 93518–19, 93531, 93536, 93560–61, 93581
- The following ZIP codes in Los Angeles County are inside our Southern California Service Area: 90001–84, 90086–91, 90093–96, 90099, 90101, 90103, 90189, 90201–02, 90209–13, 90220–24, 90230–33, 90239–42, 90245, 90247–51, 90254–55, 90260–67, 90270, 90272, 90274–75, 90277–78, 90280, 90290–96, 90301–12, 90401–11, 90501–10, 90601–10, 90623, 90630–31, 90637–40, 90650–52, 90660–62, 90670–71, 90701–03, 90706–07, 90710–17, 90723, 90731–34, 90744–49, 90755, 90801–10, 90813–15, 90822, 90831–35, 90840, 90842, 90844, 90846–48, 90853, 90895, 90899, 91001, 91003, 91006–12, 91016–17, 91020–21, 91023–25, 91030–31, 91040–43, 91046, 91066, 91077, 91101–10, 91114–18, 91121, 91123–26, 91129, 91182, 91184–85, 91188–89, 91199, 91201–10, 91214, 91221–22, 91224–26, 91301–11, 91313, 91316, 91321–22, 91324–31, 91333–35, 91337, 91340–46, 91350–57, 91361–62, 91364–65, 91367, 91371–72, 91376, 91380–87, 91390, 91392–96, 91401–13, 91416, 91423, 91426, 91436, 91470, 91482, 91495–96, 91499, 91501–08, 91510, 91521–23, 91526, 91601–12, 91614–18, 91702, 91706, 91709, 91711, 91714–16, 91722–24, 91731–35, 91740–41, 91744–50, 91754–56, 91765–73, 91775–76, 91778, 91780, 91788–93, 91795, 91801–04, 91896, 91899, 93243, 93510, 93532, 93534–36, 93539, 93543–44, 93550–53, 93560, 93563, 93584, 93586, 93590–91, 93599
- All ZIP codes in Orange County are inside our Southern California Service Area: 90620–24, 90630–33, 90638, 90680, 90720–21, 90740, 90742–43, 92602–07, 92609–10, 92612, 92614–20, 92623–30, 92637, 92646–63, 92672–79, 92683–85, 92688, 92690–94, 92697–98, 92701–08, 92711–12, 92728, 92735, 92780–82, 92799, 92801–09, 92811–12, 92814–17, 92821–23, 92825, 92831–38, 92840–46, 92850, 92856–57, 92859, 92861–71, 92885–87, 92899
- The following ZIP codes in Riverside County are inside our Southern California Service Area: 91752, 92201–03, 92210–11, 92220, 92223, 92230, 92234–36, 92240–41, 92247–48, 92253–55, 92258, 92260–64, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501–09, 92513–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92589–93, 92595–96, 92599, 92860, 92877–83
- The following ZIP codes in San Bernardino County are inside our Southern California Service Area: 91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758–59, 91761–64, 91766, 91784–86, 91792, 92252, 92256, 92268, 92277–78, 92284–86, 92305, 92307–08, 92313–18, 92321–22, 92324–26, 92329, 92331, 92333–37, 92339–41, 92344–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–95, 92397, 92399, 92401–08, 92410–15, 92418, 92423–24, 92427, 92880

- The following ZIP codes in San Diego County are inside our Southern California Service Area: 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–47, 91950–51, 91962–63, 91976–80, 91987, 92003, 92007–11, 92013–14, 92018–30, 92033, 92037–40, 92046, 92049, 92051–52, 92054–61, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92081–86, 92088, 92091–93, 92096, 92101–24, 92126–32, 92134–40, 92142–43, 92145, 92147, 92149–50, 92152–55, 92158–79, 92182, 92184, 92186–87, 92190–91, 92193, 92195–99
- The following ZIP codes in Ventura County are inside our Southern California Service Area: 90265, 91304, 91307, 91311, 91319–20, 91358–62, 91377, 93001–07, 93009–12, 93015–16, 93020–22, 93030–36, 93040–44, 93060–66, 93094, 93099, 93252

For each ZIP code listed for a county, the Member's Home Region Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside the Member's Home Region Service Area, unless that other county is listed above and that ZIP code is also listed for that other county. If you have a question about whether a ZIP code is in the Member's Home Region Service Area, please call our Member Service Call Center.

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

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

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

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

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

Only the Member for whom we have received the appropriate Premiums is entitled to coverage under this *Membership Agreement and Evidence of Coverage*, and then only for the period for which we have received payment. The Applicant must prepay the Premiums listed on their approval letter, applicable to your child's coverage, for each

month on or before the last day of the preceding month. **We may amend the Premiums listed on the Rate Sheet upon 60 days prior written notice, as described under "Term and amendment of this Membership Agreement and Evidence of Coverage" in the "Introduction" section.** Also, your Premiums may change if you add coverage for another child or drop coverage for a child. Only Members for whom we have received the appropriate Premiums are entitled to coverage under this *Membership Agreement and Evidence of Coverage*, and then only for the period for which we have received payment.

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

Who Is Eligible

General requirements

To enroll a child and continue enrollment in our Child Health Plan, all of the following requirements must be met:

- The Applicant must be 19 years old or older who is the parent or legal guardian
- The child must be under age 19
- The child **is not eligible** for government or employer-sponsored health care coverage, or will lose health care

coverage within 90 days of the Child Health Plan application . Government health care coverage includes full scope Medi-Cal, Healthy Families or CCS (California Children's Services)

- Family income must be less than 300 percent of the Federal Income Guidelines. The Federal Income Guidelines ("FIG") is the amount of money the federal government determines a family requires to meet basic needs. The FIG standard changes during the first quarter of every year
- After the initial 24 months of enrollment and at each subsequent 24 month renewal period, the Applicant must prove that the Member still meets all eligibility requirements of Child Health Plan membership

Note: A child of a Child Health Plan Member may be eligible provided the child meets all of the eligibility criteria.

Who Is Not Eligible

A child meeting any of the following requirements is barred from enrollment in our Child Health Plan:

- A minor (someone 18 years old or younger) cannot apply for coverage on their own behalf as the Applicant
- An emancipated minor (someone younger than age 18 who has been granted the status of adulthood by a court order or other formal arrangement) with or without children is not eligible for membership in Child Health Plan
- Unborn children are not eligible for membership in Child Health Plan
- A child enrolled in or eligible for any other government health coverage, who will not lose coverage within 90 days of the time the Child Health Plan application is submitted, are not eligible for membership in Child Health Plan. Other coverage includes government coverage such as Full Scope Medi-Cal, Healthy Families or CCS (California Children's Services).

Children who are covered under CCS will be denied enrollment in Child Health Plan **unless** they have been receiving services from Kaiser Permanente providers for their CCS condition as Medi-Cal, Healthy Families or commercial members and denying their application for Child Health Plan would effectively disrupt their health care. Please refer to the “Exclusions” section in the “Exclusions, Limitations, and Reductions” section for additional information on CCS eligibility

- A child enrolled in any other employer-sponsored health coverage who will not lose coverage within 90 days of the time the Child Health Plan application is submitted. If an employer offers to pay all or some portion of your child(ren)’s health coverage, they are not eligible for Child Health Plan
- Persons who have had entitlement to receive Services through the Child Health Plan terminated for cause are not eligible
- Persons who have had entitlement to receive Services through Child Health Plan terminated three times in any 12-month period for failure to pay Premiums cannot enroll for 12 months after the third termination date are not eligible. For the purposes of this paragraph, a termination does not count if we reinstated a Member’s entitlement to receive Services because you made full payment on or before the next scheduled payment due date following the one you missed
- An Applicant’s spouse is not eligible for membership

Note: A Member may be ineligible to enroll in the Child Health Plan if that plan

has reached our membership capacity limit. Once our membership capacity limit is reached, the Child Health Plan will suspend enrollment of new applicants until space becomes available.

Service Area eligibility requirements

When joining Kaiser Permanente, the Member is enrolling in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), which we call the "Home Region." The Service Area of each Region is described in the "Definitions" section of this *Membership Agreement and Evidence of Coverage*. The enrolled Member must live inside our Service Area. The coverage information in this *Membership Agreement and Evidence of Coverage* applies when the Member obtains care in their Home Region. When the Member visits the other California Region, they may receive care as described in "Visiting Other Regions" in the "How to Obtain Services" section of this *Membership Agreement and Evidence of Coverage*.

If the Member moves from their Home Region to the other California Region, we will transfer their membership to the Child Health Plan in that Region. All terms and conditions in the Health Coverage Application, including the Conditions of Acceptance and Arbitration Agreement, will continue to apply. We will provide you with the effective date of coverage and a Kaiser Permanente ID card for each Member of the Family with a new medical record number on it. For more information, please call our Member Service Call Center..

If the enrolled Member moves to the service area of a Region outside California, they are not eligible for membership under this *Agreement*. You may be able to apply for membership on behalf of the Member in that Region by contacting the member or customer service department there, but the plan, including coverage, premiums, and eligibility requirements will not be the same. For

the purposes of this eligibility rule, the service areas of the Regions outside California may change on January 1 of each year and are currently the District of Columbia and parts of Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington. For more information, please call our Member Service Call Center.

Anytime a Member moves outside our Service Area, you must notify us in writing, or call Billing/DPA at **1-888-236-4490** or Member Services at **1-800-464-4000** and the Member's membership will terminate on the last day of the month in which we receive the notice. Send the notice to Kaiser Permanente, California Service Center, P.O. Box 232407, San Diego, CA 92193.

Recertification of eligibility

We will notify you approximately three months before your 24-month membership ends. At that time you must verify that the Member continues to live in a Service Area, that the Member is not eligible for or enrolled in other coverage, and that the family income continues to meet the income requirement for participation in the Child Health Plan. You must provide all information requested by Health Plan to determine whether the Member is eligible for continued enrollment in the Child Health Plan. You must notify Health Plan immediately of any changes in meeting any of the eligibility criteria specified in this "Who is Eligible" section. Failure to provide such information (recertify) or to meet the eligibility criteria will result in loss of eligibility.

How to Enroll

The Applicant may request a Child Health Plan enrollment application by calling **1-800-464-4000 (1-800-777-1370 TTY)**. All applications are subject to income screening. Please allow 45 business days to process a new application. If we approve your enrollment application, we will send you billing information within 30 days of approval. You will have 45 days from the effective date to pay the bill. If your Child Health Plan coverage begins when your group coverage ends (including group continuation coverage), the first payment to us will include coverage from when your group coverage ended through our current billing cycle.

If the Applicant does not send us the Premium payment by the due date on the bill, the child will be disenrolled from the Child Health Plan and the membership is void.

If the Applicant would like to give permission to another party to inquire about a Member's status, the Applicant may complete the Third Party Authorization section of the KP Child Health Plan application. The Applicant can modify this request at any time by calling Charitable Health Coverage Operations at **1-800-255-5053**.

Effective date of coverage. The effective date of coverage for applications approved by the 20th of the month will be the first day of the following month. The effective date of coverage for applications approved after the 20th of the month will be the first day of the second following month. Membership begins at 12:00 a.m. on the effective date.

Adding new child to an existing account

To add a newborn, newly adopted child, or child placed with you or your Spouse for adoption, the child must meet all of the eligibility requirements in this "Who is Eligible" section and the Applicant must complete and submit a Child Health Plan

Membership Update form. To get a Child Health Plan Membership Update form call Member Services at **1-800-464-4000**. You can submit the completed form in one of the following ways:

- by U.S. Postal Service to:
Charitable Health Coverage
Operations
P.O. Box 12904
Oakland, CA 94604
- by fax to **1-868-876-3211**

Effective date of coverage. When a new child is added to an existing account the effective date of coverage is as follows:

- For a newborn child, born to an existing Member, coverage is effective from the moment of birth (any Premiums required for the newborn will be effective the first of the month following birth). However, if the newborn child is not enrolled within 31 days, the newborn is covered for only 31 days (including the date of birth)
- For a newborn child not born to an existing member the effective date of coverage for applications approved by the 20th of the month will be the first day of the following month. The effective date of coverage for applications approved after the 20th of the month will be the first day of the second following month
- For a newly adopted child (including a child placed with you for adoption) coverage is effective on first day of the month following the date when the adopting parent gains the legal right to control the child's health care. For purposes of this requirement, "legal right to control health care" means you have a signed written document (such as a health facility minor release report, a

medical authorization form, or a relinquishment form) or other evidence that shows you or your Spouse have the legal right to control the child's health care

Membership Limits

Health Plan reserves the right to limit enrollment in the Child Health Plan and to discontinue the Child Health Plan at any time. Membership in the Child Health Plan will be closed (except for newborns and newly adopted children) when the Child Health Plan membership limit is reached. Additionally, if necessary to maintain satisfactory service to existing Members, Health Plan may suspend enrollment of additional Members (except newborns and newly adopted children). The memberships of children added after the first child will terminate on the same date as the first child.

How to Obtain Services

As the Applicant, you are selecting our medical care program to provide your Child's health care. Your Child(ren) must receive all covered care from Plan Providers inside the Home Region Service Area, except as described in the sections listed below for the following Services:

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

The member is enrolled in one of two Health Plan Regions in California (either our Northern

California Region or Southern California Region), called your Home Region. The coverage information in this *Membership Agreement and Evidence of Coverage* applies when the Member obtains care in your Home Region.

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

Routine Care

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

- Preventive Care Services
- Periodic follow-up care (regularly scheduled follow-up care, such as visits to monitor a chronic condition)
- Other care that is not Urgent Care

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

Urgent Care

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think a Member may need Urgent Care, call the appropriate appointment or advice telephone number at a Plan Facility. Please refer to *Your Guidebook* for appointment and advice telephone numbers.

For information about Out-of-Area Urgent Care, please refer to "Urgent Care" in the

"Emergency Services and Urgent Care" section.

Not Sure What Kind of Care You Need?

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

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

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

Your Personal Plan Physician

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

We encourage each Member to choose a personal Plan Physician. Members may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in

obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians.

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

Getting a Referral

Referrals to Plan Providers

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

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

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

Medical Group authorization procedure for certain referrals

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

- **Durable medical equipment.** If a Member's 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 the Member's durable medical equipment coverage includes the item and that the item is listed on our formulary their 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
- **Home health care.** If a Member's Plan Physician makes a written referral for at least eight continuous hours of home health nursing or other care, the Medical Group's designee Plan Physician or committee will authorize the Services if the designee determines that they are Medically Necessary and that they are not

the types of Services that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training

- **Ostomy and urological supplies.** If a Member's 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 the Member's 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 a Member's Plan Physician decides that the Member requires covered Services not available from Plan Providers, he or she will recommend to the Medical Group that the Member be referred to a Non-Plan Provider inside or outside their Home Region 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 the Member 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 a Member's condition, but no later than five business days after receiving all of the information (including additional examination and test results) reasonably necessary to make the decision, except that decisions about urgent Services will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If the Medical Group needs more time to make the decision because it doesn't have information reasonably necessary to make the decision, or because it has requested consultation by a particular specialist, the Member and their 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.

A Member's treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, the

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

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

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

Second Opinions

If you want a second opinion, you can either ask your Plan Physician to help you arrange one, or you can make an appointment with another Plan Physician. If there isn't a Plan Physician who is an

appropriately qualified medical professional for your condition, the appropriate Medical Group designee will authorize a consultation with a non-Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within his or her scope of practice and who possesses a clinical background related to the illness or condition associated with the request for a second medical opinion.

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

- A Member's 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 the Member's 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 there isn't a Plan Physician who is an appropriately qualified medical professional for the Member's condition, the Medical Group will authorize a referral to a Non-Plan Physician for a 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 a 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 the Member obtains from Plan Providers or Non-Plan Providers.

Breach of contract

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

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

If our contract with any Plan Provider terminates while the Member is under the care of that provider, we will retain financial responsibility for covered care the Member receives from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. We will give you 60 days

prior written notice (or as soon as reasonably possible) if a contracted provider group or hospital terminates a contract with us and the Member might be materially and adversely affected.

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

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

less. We may cover completion of these Services for the duration of the illness

- Care for children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the termination date of the terminated provider, or (2) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of the termination date of the terminated provider

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

- A Member's Child Health Plan coverage is in effect on the date they receive the Service
- The Member is receiving Services in one of the cases listed above from the terminated Plan Provider on the provider's termination date
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside our Service Area
- The Services to be provided to the Member would be covered Services under this *Membership Agreement and Evidence of Coverage* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from the termination date of the Plan Provider

Cost Sharing. The Cost Sharing for completion of Services is the Cost Sharing required for Services provided by a Plan

Provider as described in the "Benefits and Cost Sharing" section.

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

Visiting Other Regions

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

The 90-day limit on visiting member care does not apply to Members who attend 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 the Member goes to a provider for covered care. When Member gets care, please bring their Kaiser Permanente ID card and a photo ID. A Member's medical record number is used to identify their medical records and membership information. A Member's medical record number should never change. Please call our Member Service Call

Center if we ever inadvertently issue the Member more than one medical record number or if the Member needs to replace your Kaiser Permanente ID card.

ID cards are for identification only. To receive covered Services, the Member 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 a Member lets someone else use their ID card, we may keep their ID card and terminate their 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 the Member receives from Kaiser Permanente. If you have any questions or concerns, please discuss them with the Member's personal Plan Physician or with other Plan Providers who are treating the Member. They are committed to your satisfaction and want to help you with your questions.

Member Services

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

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

Interpreter services

If you need interpreter services when you call us or when a Member gets 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, a Member can usually receive all the covered Services they need, including specialty care, pharmacy, and lab work. Members are not restricted to a particular Plan Facility, and we encourage Members to use the facility that will be most convenient for them:

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

- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (refer to *Your Guidebook* for locations in your area)

Plan Hospitals and Plan Medical Offices

The following is a list of Plan Hospitals and most Plan Medical Offices in the Service Area of our Northern California and Southern California Regions. As a Member, you are enrolled in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), called the Home Region. The coverage information in this *Membership Agreement and Evidence of Coverage* applies when the Member obtains care in their Home Region. When the Member visits the other California Region, they may receive care from Plan Facilities in that Region as described on "Visiting Other Regions" in the "How to Obtain Services" section. Please refer to *Your Guidebook* for the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. Additional Plan Medical Offices are listed in *Your Guidebook* and on our website at **kp.org**. This list is subject to change at any time without notice. If you have any questions about the current locations of Plan Facilities, please call our Member Service Call Center.

Northern California Region Plan Facilities

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 Mateo

- Medical Offices: 1000 Franklin 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.

Southern California Region Plan Facilities

Aliso Viejo

- Medical Offices: 24502 Pacific Park Dr.

Anaheim

- Hospital and Medical Offices: 441 N. Lakeview Ave.
- Medical Offices: 411 N. Lakeview Ave., 5475 E. La Palma Ave., and 1188 N. Euclid St.

Bakersfield

- Hospital: 2615 Chester Ave. (San Joaquin Community Hospital)
- Medical Offices: 1200 Discovery Dr., 3501 Stockdale Hwy., 3700 Mall View Rd., 4801 Coffee Rd., and 8800 Ming Ave.

Baldwin Park

- Hospital and Medical Offices: 1011 Baldwin Park Blvd.

Bellflower

- Medical Offices: 9400 E. Rosecrans Ave.

Bonita

- Medical Offices: 3955 Bonita Rd.

Brea

- Medical Offices: 1900 E. Lambert Rd.

Camarillo

- Medical Offices: 2620 E. Las Posas Rd.

Carlsbad

- Medical Offices: 6860 Avenida Encinas

Chino

- Medical Offices: 11911 Central Ave.

Claremont

- Medical Offices: 250 W. San Jose St.

Colton

- Medical Offices: 789 S. Cooley Dr.

Corona

- Medical Offices: 2055 Kellogg Ave.

Cudahy

- Medical Offices: 7825 Atlantic Ave.

Culver City

- Medical Offices: 5620 Mesmer Ave.

Diamond Bar

- Medical Offices: 1336 Bridge Gate Dr.

Downey

- Hospital: 9333 E. Imperial Hwy.
- Medical Offices: 9449 E. Imperial Hwy.

El Cajon

- Medical Offices: 1630 E. Main St.

Escondido

- Hospital: 555 E. Valley Pkwy.
(Palomar Medical Center)
- Medical Offices: 732 N. Broadway St.

Fontana

- Hospital and Medical Offices:
9961 Sierra Ave.

Garden Grove

- Medical Offices: 12100 Euclid St.

Gardena

- Medical Offices: 15446 S. Western
Ave.

Glendale

- Medical Offices: 444 W. Glenoaks
Blvd.

Harbor City

- Hospital and Medical Offices: 25825 S.
Vermont Ave.

Huntington Beach

- Medical Offices: 18081 Beach Blvd.

Indio

- Hospital: 47111 Monroe St. (John F.
Kennedy Memorial Hospital)
- Medical Offices: 81-
719 Doctor Carreon Blvd.

Inglewood

- Medical Offices: 110 N. La Brea Ave.

Irvine

- Hospital and Medical Offices: 6640 Alton
Pkwy.
- Medical Offices: 6 Willard St.

Joshua Tree

- Hospital: 6601 White Feather Rd. (Hi-
Desert Medical Center)
- Please refer to *Your Guidebook* for other Plan
Providers in the Yucca Valley–Twentynine
Palms area

La Mesa

- Medical Offices: 8080 Parkway Dr. and
3875 Avocado Blvd.

La Palma

- Medical Offices: 5 Centerpointe Dr.

Lancaster

- Hospital: 1600 W. Avenue J
(Antelope Valley Hospital)
- Medical Offices: 43112 N. 15th St. W.

Long Beach

- Medical Offices: 3900 E. Pacific Coast Hwy.

Los Angeles

- Hospitals and Medical Offices: 1526 N.
Edgemont St. and 6041 Cadillac Ave.
- Medical Offices: 5119 E. Pomona Blvd.,
1550 W. Manchester Ave., and 12001 W.
Washington Blvd.

Lynwood

- Medical Offices: 3840 Martin Luther King Jr.
Blvd.

Mission Hills

- Medical Offices: 11001 Sepulveda Blvd.

Mission Viejo

- Medical Offices: 23781 Maquina Ave.

Montebello

- Medical Offices: 1550 Town Center Dr.

Moreno Valley

- Hospital: 27300 Iris Ave.
(Moreno Valley Community Hospital)
- Medical Offices: 12815 Heacock St.

Murrieta

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

Oceanside

- Medical Offices: 3609 Ocean Ranch Blvd.

Ontario

- Medical Offices: 2295 S. Vineyard Ave.

Oxnard

- Medical Offices: 2200 E. Gonzales Rd.

Palm Desert

- Medical Offices: 75-036 Gerald Ford Dr.

Palm Springs

- Hospital: 1150 N. Indian Canyon Dr.
(Desert Regional Medical Center)
- Medical Offices: 1100 N. Palm Canyon Dr.

Palmdale

- Medical Offices: 4502 E. Avenue S

Panorama City

- Hospital and Medical Offices:
13652 Cantara St.

Pasadena

- Medical Offices: 3280 E. Foothill Blvd.

Rancho Cucamonga

- Medical Offices: 10850 Arrow Rte.

Redlands

- Medical Offices: 1301 California St.

Riverside

- Hospital and Medical Offices: 10800 Magnolia Ave.

San Bernardino

- Medical Offices: 1717 Date Pl.

San Diego

- Hospital and Medical Offices: 4647 Zion Ave.
- Medical Offices: 3250 Wing St.,
4405 Vandever Ave., 4650 Palm Ave.,
7060 Clairemont Mesa Blvd., and
11939 Rancho Bernardo Rd.

San Dimas

- Medical Offices: 1255 W. Arrow Hwy.

San Juan Capistrano

- Medical Offices: 30400 Camino Capistrano

San Marcos

- Medical Offices: 400 Craven Rd.

Santa Ana

- Medical Offices: 3401 S. Harbor Blvd. and
1900 E. 4th St.

Santa Clarita

- Medical Offices: 27107 Tourney Rd.

Simi Valley

- Medical Offices: 3900 Alamo St.

Temecula

- Medical Offices: 27309 Madison Ave.

Thousand Oaks

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

Torrance

- Medical Offices: 20790 Madrona Ave.

Upland

- Medical Offices: 1183 E. Foothill Blvd.

Ventura

- Hospital: 147 N. Brent St. (Community Memorial Hospital of San Buenaventura)
- Medical Offices: 888 S. Hill Rd.

Victorville

- Medical Offices: 14011 Park Ave.

West Covina

- Medical Offices: 1249 Sunset Ave.

Whittier

- Medical Offices: 12470 Whittier Blvd.

Wildomar

- Hospital: 36485 Inland Valley Dr. (Inland Valley Medical Center)
- Medical Offices: 36450 Inland Valley Dr.

Woodland Hills

- Hospital and Medical Offices: 5601 De Soto Ave.
- Medical Offices: 21263 Erwin St.

Yorba Linda

- Medical Offices: 22550 E. Savi Ranch Pkwy.

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 the Member at another facility.

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

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

Emergency Services and Urgent Care

Emergency Services

If a Member has an Emergency Medical Condition, call **911** (where available) or go to the nearest hospital Emergency Department. The Member does not need prior authorization for Emergency Services. When a Member has an Emergency Medical Condition, we cover

Emergency Services the Member receives from Plan Providers or Non-Plan Providers anywhere in the world as long as the Services would have been covered under the "Benefits and Cost Sharing" section (subject to the "Exclusions, Limitations, and Reductions" section) if the Member had received them from Plan Providers. Emergency Services are available from Plan Hospital Emergency Departments 24 hours a day, seven days a week.

Post-Stabilization Care

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

To request authorization to receive Post-Stabilization Care from a Non-Plan Provider, you must call us toll free at **1-800-225-8883** (TTY users call **711**) or the notification telephone number on the Member's Kaiser Permanente ID card *before* they 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 the Member's 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 the Member's care, we may authorize special transportation services that are medically required to get the Member 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 the Member is unconscious. In these cases, you must call us as soon as reasonably possible. Please keep in mind that anyone can call us for the Member. We do not cover any care the Member receives from Non-Plan Providers after the Member's Emergency Medical Condition is Stabilized unless we authorize it, so if you don't call as soon as reasonably possible, you increase the risk that you will have to pay for this care.

Cost Sharing

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

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

would be the Cost Sharing listed under "Hospital Inpatient Care"

Services not covered under this "Emergency Services" section

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

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

Urgent Care

Inside the Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think the Member may need Urgent Care, call the appropriate appointment or advice telephone number at a Plan Facility. Please refer to *Your Guidebook* for appointment and advice telephone numbers.

Out-of-Area Urgent Care

If the Member has 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 their (or their unborn child's) health from a Non-

Plan Provider if all of the following are true:

- The Member receives the Services from Non-Plan Providers while they are temporarily outside their Home Region Service Area
- The Member reasonably believed that their (or their unborn child's) health would seriously deteriorate if they delayed treatment until they returned to their Home Region Service Area

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

Cost Sharing

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

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

Services not covered under this "Urgent Care" section

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

- Follow-up care and other Services that are not Urgent Care or Out-of-Area Urgent Care

described in this "Urgent Care" section (refer to the "Benefits and Cost Sharing" section for coverage, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)

Payment and Reimbursement

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

We will reduce any payment we make to you or the Non-Plan Provider by applicable Cost Sharing.

How to file a claim

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

- As soon as possible, send us a completed claim form. You can get a claim form by visiting our website at **kp.org** or by calling our Member Service Call Center toll free at **1-800-464-4000** or **1-800-390-3510** (TTY users call **1-800-777-1370**). One of our representatives will be happy to assist you if you need help completing our claim form

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

For Northern California Members:

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

For Southern California Members:

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

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

We will send you our written decision within 45 business days after we receive the claim unless we request additional information from you or the Non-Plan Provider. If we request additional information, we will send our written decision no

later than 45 business days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in the letter, we will make our decision based on the information we have. If our decision is not fully in your favor, we will tell you the reasons and how to file a grievance as described under "Grievances" in the "Dispute Resolution" section.

Benefits and Cost Sharing

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

- A Member's Health Plan coverage is in effect on the date they receive the Service
 - The Services are Medically Necessary
 - The Services are one of the following:
 - ◆ health care items and services for preventive care
 - ◆ health care items and services for diagnosis, assessment, or treatment
 - ◆ health education covered under "Health Education" in this "Benefits and Cost Sharing" section
 - ◆ other health care items and services
 - The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the sections listed below for the following Services:
 - ◆ drugs prescribed by dentists as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section
 - ◆ emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
 - ◆ Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
 - ◆ eyeglasses and contact lenses prescribed by Non-Plan Providers as described under "Vision Services" in this "Benefits and Cost Sharing" section
- The Member receives the Services from Plan Providers inside their Home Region Service Area, except where specifically noted to the contrary in the sections listed below for the following Services:
 - ◆ authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
 - ◆ emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
 - ◆ Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
 - ◆ hospice care as described under "Hospice Care" in this "Benefits and Cost Sharing" section
 - The Medical Group has given prior authorization for the Services if required under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

The only Services we cover under this *Membership Agreement and Evidence of Coverage* are those that this "Benefits and Cost Sharing" section says that we cover, subject to exclusions and limitations described in this "Benefits and Cost Sharing" section and to all

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

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

Cost Sharing

General rules, examples, and exceptions

A Member's Cost sharing for covered Services will be the Cost Sharing in effect on the date they receive the Services, except as follows:

- If a Member is receiving covered inpatient hospital or Skilled Nursing Facility Services on the effective date of this *Membership Agreement and Evidence of Coverage*, you pay the Cost Sharing in effect on the Member's admission date until they are discharged if the Services were covered under the Member's prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under the Member's 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 the Member 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 the Member still has coverage for it on the date they receive it) and you may be required to pay the Cost Sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription

Receiving a bill. In most cases, we will ask you to make a payment toward the Member's Cost Sharing at the time you check in. Keep in mind that this payment may cover only a portion of the total Cost Sharing for the covered Services the Member receives, and we will bill you for any additional Cost Sharing amounts that are due. The following are examples of when you may get a bill:

- The Member receives Services during their visit that were not scheduled when payment was made at check-in. For example, if the Member is scheduled to receive treatment for an existing condition, at check-in we will ask you to pay the Cost Sharing that applies to these Services. If during the Member's visit their provider finds another problem with their health, their provider may perform or order additional unscheduled Services to diagnose their problem. You may have to pay separate Cost Sharing amounts for each of these additional unscheduled Services, in addition to the Cost Sharing amount you paid at check-in for the treatment of the Member's existing condition
- The Member receives Services from a second provider during their visit that were not scheduled when payment was made at check-in. For example, if the Member is scheduled to receive a diagnostic exam, at check-in we will ask you to pay the Cost Sharing that applies to

these Services. If during the Member's diagnostic exam their provider confirms a problem with their health, their provider may request the assistance of another provider to perform additional unscheduled Services (such as an outpatient procedure). You may have to pay separate Cost Sharing amounts for the unscheduled Services of the second provider, in addition to the Cost Sharing amount you paid at check-in for the Member's diagnostic exam

- The Member goes in for Preventive Care Services and receive non-preventive Services during their visit that were not scheduled when payment was made at check-in. For example, if the Member goes in for a routine physical maintenance exam, at check-in we will ask you to pay the Cost Sharing that applies to these Services (the Cost Sharing may be "no charge"). If during the Member's routine physical maintenance exam their provider finds a problem with their health, their provider may order non-preventive Services to diagnose their problem (such as laboratory tests). You may have to pay separate Cost Sharing amounts for the non-preventive Services performed to diagnose the Member's problem, in addition to the Cost Sharing amount you paid at check-in for the Member's routine physical maintenance exam
- At check-in, you request that we bill you for some or all of the Cost Sharing the Member will receive, and we agree to bill you

In some cases, we will not ask you to make a payment at check-in, and we will bill you for any Cost Sharing. For example, some Laboratory Departments do not collect payments at check-in, and we will instead bill you for any Cost Sharing.

Noncovered Services. If the Member receives Services that are not covered under this *Membership Agreement and Evidence of Coverage*, you may be liable for the full price of those Services. Payments you make for noncovered Services are not Cost Sharing.

Copayments and Coinsurance

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

Annual out-of-pocket maximum

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

- **\$250** per calendar year for self-only enrollment (a Family of one Member)
- **\$250** per calendar year for any one Member in a Family of two or more Members
- **\$500** per calendar year for an entire Family of two or more Members

If a Member is part of a Family of two or more Members, they will reach the annual out-of-pocket maximum either when they meet the maximum for any one Member, or when the Family reaches the Family maximum. For example, suppose a Member has reached the **\$250** maximum. For Services subject to the maximum, they will not pay any more Cost Sharing during the rest of the calendar year, but every other Member in the Family must continue to pay Cost Sharing during the calendar year until the Family reaches the **\$500** 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:

- Administered drugs

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

Copayments and Coinsurance you pay for Services that are not listed above do not apply to the annual out-of-pocket maximum. For these Services, you must pay Copayments or Coinsurance even if the Member has already reached their annual out-of-pocket maximum.

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 membership period.

Preventive Care Services

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

We cover at **no charge** the Preventive Care Services on the health care reform preventive care Services list for Members enrolled in our California Regions. This list is subject to change at any time and is available on our website at **kp.org/prevention** or by calling our Member Service Call Center. If you receive any other covered Services during a visit that includes Preventive Care Services, you will pay the applicable Cost Sharing for those other Services.

The following are examples of Preventive Care Services that are included in our health care reform preventive care Services list:

- Eye exams for refraction and preventive vision screenings
- Family planning counseling and programs
- Flexible sigmoidoscopies and screening colonoscopies
- Health education counseling and programs

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

Outpatient Care

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

- Primary and specialty care consultations, exams, and treatment (other than those described below in this

"Outpatient Care" section): **a \$5 Copayment per visit**

- Preventive Care Services:
 - ◆ routine physical maintenance exams, including well-woman exams: **no charge**
 - ◆ well-child preventive exams for Members through age 23 months: **no charge**
 - ◆ family planning counseling, or consultations to obtain internally implanted time-release contraceptives or intrauterine devices (IUDs) prescribed in accord with our drug formulary guidelines: **no charge**
 - ◆ after confirmation of pregnancy, the normal series of regularly scheduled preventive prenatal care exams and the first postpartum follow-up consultation and exam: **no charge**
 - ◆ alcohol and substance abuse screenings: **no charge**
 - ◆ developmental screenings to diagnose and assess potential developmental delays: **no charge**
 - ◆ immunizations (including the vaccine) administered to you in a Plan Medical Office: **no charge**
 - ◆ flexible sigmoidoscopies: **no charge**
 - ◆ screening colonoscopies: **no charge**
- Allergy injections (including allergy serum): **a \$3 Copayment per visit**
- Outpatient surgery and other outpatient procedures: **a \$5 Copayment per procedure**
- Voluntary termination of pregnancy: **a \$5 Copayment per procedure**
- Physical, occupational, and speech therapy: **a \$5 Copayment per visit**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program: **a \$5 Copayment per day**
- Urgent Care consultations, exams, and treatment: **a \$5 Copayment per visit**

- Emergency Department visits: a **\$35 Copayment per visit**. The Emergency Department Copayment does not apply if the Member is admitted directly to the hospital as an inpatient for covered Services, or if the Member is admitted for observation and is then admitted directly to the hospital as an inpatient for covered Services (for inpatient care, please refer to “Hospital Inpatient Care” in this “Benefits and Cost Sharing” section). However, the Emergency Department Copayment does apply if the Member is admitted for observation but is not admitted as an inpatient
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside the Member’s Home Region Service Area when care can best be provided in the Member’s home as determined by a Plan Physician: **no charge**
- Acupuncture Services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain): a **\$5 Copayment per visit**
- Blood, blood products, and their administration: **no charge**
- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to the Member in a Plan Medical Office or during home visits: **no charge**
- Some types of outpatient consultations, exams, and treatment may be available

as group appointments, which we cover at a **\$2 Copayment per visit**

Services not covered under this "Outpatient Care" section

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

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

Hospital Inpatient Care

We cover the following inpatient Services at **no charge** in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals inside the Member’s Home Region Service Area:

- Room and board, including a private room if Medically Necessary

- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when the Member is 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 the Member is discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), their Plan Physician may order a follow-up visit for the Member and their newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, please refer to "Outpatient Care" in this "Benefits and Cost Sharing" section)
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Respiratory therapy
- Medical social services and discharge planning

Services not covered under this "Hospital Inpatient Care" section

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

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

Ambulance Services

Emergency

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

- A reasonable person would have believed that the medical condition was an Emergency Medical Condition which required ambulance Services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you must pay the provider and file a claim for reimbursement

unless the provider agrees to bill us. Please refer to "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section for how to file a claim for reimbursement.

Nonemergency

Inside the Member's Home Region Service Area, we cover nonemergency ambulance and psychiatric transport van Services at **no charge** if a Plan Physician determines that the Member's 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 the Member's health. These Services are covered only when the vehicle transports the Member to or from covered Services.

Ambulance Services exclusion

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

Bariatric Surgery

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

- You complete the Medical Group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success

- A Plan Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary

For covered Services related to bariatric surgical procedures that you receive, you will pay the **Cost Sharing you would pay if the Services were not related to a bariatric surgical procedure**. For example, see "Hospital Inpatient Care" in this "Benefits and Cost Sharing" section for the Cost Sharing that applies for hospital inpatient care.

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

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

- Hotel accommodations for one companion not to exceed \$100 per day for the duration of your surgery stay, up to four days, including any hotel accommodations for which we provided reimbursement under any other evidence of coverage

Services not covered under this "Bariatric Surgery" section

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

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

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
- Medical treatment for withdrawal symptoms

You pay the following for these covered Services:

- Individual chemical dependency evaluation and treatment: **a \$5 Copayment per visit**
- Group chemical dependency treatment: **a \$2 Copayment per visit**

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

Transitional residential recovery Services

We cover up to 60 days per contract year of chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by the Medical Group. We cover these Services at **no charge**. We do not cover more than 120 days of covered care in any five-consecutive-calendar-year period. These settings provide counseling and support services in a structured environment.

Services not covered under this "Chemical Dependency Services" section

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

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

Chemical dependency Services exclusion

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

Dental and Orthodontic Services

DeltaCare USA

Children enrolled in our Child Health Plan will be automatically enrolled in a DeltaCare USA Dental HMO plan and will be assigned a dentist in their area who is accepting new patients. DeltaCare USA is administered by Delta Dental of California. You should receive a DeltaCare USA membership packet in the mail within four weeks of your child's enrollment in KP Child Health Plan. If you have specific questions regarding benefit structure, limitations, or exclusions of your DeltaCare plan, please contact Delta Dental's Customer Service department at **1-888-335-8227**.

Dental Services for radiation treatment

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

Dental anesthesia

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

- The Member is under age 7, or they are developmentally disabled, or their health is compromised
- The Member's 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.

Dental and orthodontic Services for cleft palate

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

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

Cost Sharing for dental and orthodontic Services

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

- Hospital inpatient care: **no charge**
- Outpatient consultations, exams, and treatment: **a \$5 Copayment per visit**
- Outpatient surgery and other outpatient procedures: **a \$5 Copayment per procedure**

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

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

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

Dialysis Care

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

- The Services are provided inside the Member's Home Region Service Area
- The Member satisfies all medical criteria developed by the Medical Group and by the facility providing the dialysis
- A Plan Physician provides a written referral for care at the facility

After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside the Member's Home Region Service Area at **no charge**. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor.

You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

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

- Inpatient dialysis care: **no charge**
- One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, exam, or treatment: **no charge**
- Hemodialysis treatment at a Plan Facility: **a \$5 Copayment per visit**
- All other outpatient consultations, exams, and treatment: **a \$5 Copayment per visit**

Services not covered under this "Dialysis Care" section

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

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

Dialysis Care exclusions

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

Durable Medical Equipment for Home Use

Inside the Member’s Home Region Service Area, we cover durable medical equipment for use in the Member’s home (or another location used as their 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 the Member’s 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 the

Member’s Home Region Service Area. However, if the Member moves outside their Home Region 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 the Member’s Home Region 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 a Member's condition) if the equipment would otherwise be covered and the Medical Group determines that it is Medically Necessary as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

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

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

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

Durable medical equipment for home use exclusions

- Comfort, convenience, or luxury equipment or features
- Exercise or hygiene equipment
- Nonmedical items, such as sauna baths or elevators

- Modifications to a Member's 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 health education counseling, programs, and materials that your personal Plan Physician or other Plan Providers provide during a visit covered under another part of this "Benefits and Cost Sharing" section.

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

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

You pay the following for these covered Services:

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

- Covered health education materials:
no charge

Hearing Services

We cover the following:

- Routine hearing screenings that are Preventive Care Services: **no charge**
- Hearing exams to determine the need for hearing correction: **no charge**
- Hearing tests to determine the appropriate hearing aid: **no charge**
- A **\$1,000 Allowance** 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 a Member's Allowance at the initial point of sale, you cannot use it later
- Consultations and exams to verify that the hearing aid conforms to the prescription: **no charge**
- Consultations and exams for fitting, counseling, adjustment, cleaning, and inspection after the warranty is exhausted: **no charge**

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

Services not covered under this "Hearing Services" section

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

- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Cost Sharing" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusions

- 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:

- The Member is substantially confined to their home (or a friend's or relative's home)
- The Member's condition requires the Services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide Services are not covered unless the Member is also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- A Plan Physician determines that it is feasible to maintain effective supervision and control of the Member's care in their home and that the

Services can be safely and effectively provided in their home

- The Services are provided inside the Member's Home Region Service Area

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

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

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

Home health care exclusions

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

Hospice Care

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the Member's family. A Member who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. A Member may change their 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 the Member with a terminal illness and determines that their life expectancy is 12 months or less
- The Services are provided inside the Member's Home Region Service Area or inside California but within 15 miles or 30 minutes from the Member's Home Region Service Area (including a friend's or relative's home even if the Member lives 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 the Member's 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 the Member and their family, and instruction to caregivers

- Physical, occupational, or speech therapy for purposes of symptom control or to enable the Member 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. The Member 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 the Member's 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 the Member needs 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 the Member at home
 - ◆ short-term inpatient care required at a level that cannot be provided at home

Mental Health Services

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

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

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

"Mental Disorders" include the following conditions:

- Severe Mental Illness of a person of any age. "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa
- A Serious Emotional Disturbance of a child under age 18. A "Serious Emotional Disturbance" of a child under age 18 means a condition identified as a "mental disorder" in the *DSM*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:
 - ◆ as a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to

function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment

- ◆ the child displays psychotic features, or risk of suicide or violence due to a mental disorder
- ◆ the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

For Mental Disorders other than Severe Mental Illness of a person of any age and Serious Emotional Disturbance of a child under age 18, we cover evaluation and treatment only when a Plan Physician or other Plan Provider who is a licensed health care professional acting within the scope of his or her license believes the condition will significantly improve with relatively short-term therapy.

Outpatient mental health Services

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

- Up to a combined visit limit of 20 individual and group visits per Member per calendar year that include Services for mental health evaluation and treatment as described in this "Outpatient mental health Services" section. Members who have exhausted the 20-visit limit and who meet Medical Group criteria may receive up to 20

additional group visits in the same calendar year. These visit limits do not apply to mental health Services for Severe Mental Illness of a person of any age or Serious Emotional Disturbance of a child under age 18

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

You pay the following for these covered Services:

- Individual mental health evaluation and treatment: **a \$5 Copayment per visit**
- Group mental health treatment: **a \$2 Copayment per visit**

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

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs

Inpatient psychiatric hospitalization. Subject to the day limit described under "Calendar-year day limit for inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in this "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" section, we cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians 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. Subject to the day limit described under "Calendar-year day limit for inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in this "Inpatient psychiatric

hospitalization and intensive psychiatric treatment programs" section, we cover at **no charge** the following intensive psychiatric treatment programs at a Plan Facility:

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

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

- Each day of inpatient psychiatric hospitalization counts as one day

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

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

Services not covered under this “Mental Health Services” section

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

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

Ostomy and Urological Supplies

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

About our soft goods formulary

Our soft goods formulary includes the list of ostomy and urological supplies that have been approved by our Soft Goods Formulary Executive Committee for our Members. Our Soft Goods Formulary Executive Committee is responsible for

reviewing and revising the soft goods formulary. Our soft goods formulary is periodically updated to keep pace with changes in medical technology and clinical practice. To find out whether a particular ostomy or urological supply is included in our soft goods formulary, please call our Member Service Call Center.

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

Ostomy and urological supplies exclusion

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Special Procedures

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

- Imaging Services that are Preventive Care Services:
 - ◆ preventive mammograms: **no charge**
 - ◆ preventive aortic aneurysm screenings: **no charge**
 - ◆ bone density CT scans: **no charge**
 - ◆ bone density DEXA scans: **no charge**

- All other CT scans, and all MRIs and PET scans: **no charge**
- All other imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds: **no charge** except that certain imaging procedures are covered at a **\$5 Copayment per procedure** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
- Nuclear medicine: **no charge**
- Laboratory tests:
 - ◆ laboratory tests to monitor the effectiveness of dialysis: **no charge**
 - ◆ fecal occult blood tests: **no charge**
 - ◆ routine preventive laboratory tests and screenings that are Preventive Care Services, such as preventive cervical cancer screenings, prostate specific antigen tests, cholesterol tests (lipid panel and profile), diabetes screening (fasting blood glucose tests), certain sexually transmitted disease (STD) tests, and HIV tests: **no charge**
 - ◆ all other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available): **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 **\$5 Copayment per procedure** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort

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

Outpatient Prescription Drugs, Supplies, and Supplements

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

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

How to obtain covered items

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

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

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

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
- Diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills)
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs

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

- Items other than those described below in this "Cost Sharing for outpatient drugs, supplies, and supplements" section: **a \$5 Copayment** 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 *Membership Agreement and Evidence of Coverage* is amended to exclude a drug that we have been covering and providing to you under this *Membership Agreement and Evidence of Coverage*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration): **50% Coinsurance** for up to a 30-day supply in a 30-day period
- Diaphragms and cervical caps: **a \$5 Copayment per item**

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

Certain intravenous drugs, supplies, and supplements

We cover certain self-administered intravenous drugs, fluids, additives, and

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

Diabetes urine-testing supplies and insulin-administration devices

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

We cover the following insulin-administration devices at **a \$5 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 the Member. Upon payment of the Cost Sharing specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, the Member 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 a Member wishes to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit.

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 a Member's Plan Physician will prescribe it for a particular medical condition.

Our drug formulary guidelines allows Members 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 a Member's 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 a Member to participate in a behavioral intervention program approved by the Medical Group for specific conditions and you may be required to pay for the program.

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

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

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

Outpatient prescription drugs, supplies, and supplements exclusions

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

Prosthetic and Orthotic Devices

We cover the prosthetic and orthotic devices specified in this "Prosthetic and Orthotic Devices"

section if all of the following requirements are met:

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

Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to loss or misuse), and Services to determine whether a Member needs a prosthetic or orthotic device. If we cover a replacement device, then you pay the Cost Sharing that you would pay for obtaining that device.

Internally implanted devices

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

External devices

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

- 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 under these headings in 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

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

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

Reconstructive Surgery

We cover the following reconstructive surgery Services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible
- Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

You pay the following for covered reconstructive surgery Services:

- Outpatient consultations, exams, and treatment: **a \$5 Copayment per visit**
- Outpatient surgery: **a \$5 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 under these headings in this "Benefits and Cost Sharing" section:

- Dental and orthodontic Services that are an integral part of reconstructive

surgery for cleft palate (refer to "Dental and Orthodontic Services")

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

Reconstructive surgery exclusions

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

Services Associated with Clinical Trials

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

- The Member is diagnosed with cancer
- The Member is accepted into a phase I, II, III, or IV clinical trial for cancer
- The Member's treating Plan Physician, or their 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 the Member
- The Services would be covered under this *Membership Agreement and Evidence of*

Coverage if they were not provided in connection with a clinical trial

- The clinical trial has a therapeutic intent, and its end points are not defined exclusively to test toxicity
- The clinical trial involves a drug that is exempt under federal regulations from a new drug application, or the clinical trial is approved by: one of the National Institutes of Health, the federal Food and Drug Administration (in the form of an investigational new drug application), the U.S. Department of Defense, or the U.S. Department of Veterans Affairs

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

Services associated with clinical trials exclusions

- Services that are provided solely to satisfy data collection and analysis needs and are not used in the Member's 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 the Member's Home Region Service Area, we cover at **no charge** up to 100 days per contract year (including any days we covered under any other evidence of coverage) of skilled inpatient Services in a Plan Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

We cover the following Services:

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

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

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

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

Transplant Services

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

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

- If either the Medical Group or the referral facility determines that the Member does not satisfy its respective criteria for a transplant, we will only cover Services the Member receives 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 the Member, 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 a Member receives, you will pay the **Cost Sharing you would pay if the Services were not related to a transplant**. For example, see "Hospital Inpatient Care" in this "Benefits and Cost Sharing" section for the Cost Sharing that applies for hospital inpatient care.

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

Services not covered under this "Transplant Services" section

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

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

Vision Services

We cover the following:

- Routine vision screenings that are Preventive Care Services: **no charge**
- Eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses: **no charge**

Optical Services

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

The date we provide an Allowance toward (or otherwise cover) an item under this "Optical Services" section is the date on which you order the item. For example, if we last provided an Allowance toward an item you ordered on May 1, 2011, and if we provide an Allowance not more than once every 24 months for that type of item, then we would not provide another Allowance toward that type of item until on or after May 1, 2013. You can use the Allowances under this "Optical Services" section only when you first order an item. If you use part but not all of an Allowance when you first order an item, you cannot use the rest of that Allowance later.

Eyeglasses and contact lenses. We provide a single **\$125 Allowance** toward the purchase price of any or all of the following every 24 months when a physician or optometrist prescribes an eyeglass lens (for eyeglass lenses and frames) or contact lens (for contact lenses):

- 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) eyeglass lenses or frames within the previous 24 months.

Replacement lenses. 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 of an eyeglass lens or contact lens that we provided an Allowance toward (or otherwise covered) we will provide an Allowance toward the purchase price of a replacement item of the same type (eyeglass lens, or contact lens, fitting, and dispensing) for the eye that had the .50 diopter change. The Allowance toward one of these replacement lenses is **\$30** for a single vision eyeglass lens or for a contact lens (including fitting and dispensing) and **\$45** for a multifocal or lenticular eyeglass lens **Special contact lenses for aniridia and aphakia.** We cover the following special contact lenses when prescribed by a Plan Physician or Plan Optometrist:

- Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris): **no charge.**

We will not cover an aniridia contact lens if we provided an Allowance toward (or otherwise covered) more than one aniridia contact lens for that eye within the previous 12 months

- Up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year to treat aphakia (absence of the crystalline lens of the eye) for Members through age 9: **no charge.** We will not cover an aphakic contact lens if we provided an Allowance toward (or otherwise covered) more than six aphakic contact lenses for that eye during the same calendar year

Special contact lenses that provide a significant vision improvement not obtainable with eyeglasses. If a Plan Physician or Plan

Optometrist prescribes contact lenses (other than contact lenses for aniridia or aphakia) that will provide a significant improvement in your vision that eyeglass lenses cannot provide, we cover either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (including fitting and dispensing) not more than once every 24 months at **no charge.** We will not cover any contact lenses under this "Special contact lenses that provide a significant vision improvement not obtainable with eyeglasses" section if we provided an Allowance toward (or otherwise covered) a contact lens within the previous 24 months, but not including any of the following:

- Contact lenses for aniridia or aphakia

Services not covered under this "Vision Services" section

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

- Services related to the eye or vision other than Services covered under this "Vision Services" section, such as outpatient surgery and outpatient prescription drugs, supplies, and

supplements (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 contact lenses, eyeglass lenses, and frames
- Eyeglass or contact lens adornment, such as engraving, faceting, or jewelry
- Low-vision devices
- Items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits

Exclusions, Limitations, and Reductions

Exclusions

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

description of that benefit in the "Benefits and Cost Sharing" section.

Artificial insemination and conception by artificial means

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

California Children's Services

Children who are enrolled in Child Health Plan and later diagnosed with a CCS-eligible condition will receive all benefits for which they are covered under Child Health Plan and will be referred to CCS for any care that is not covered under Child Health Plan.

Certain exams and Services

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

Chiropractic Services

Chiropractic Services and the Services of a chiropractor.

Cosmetic Services

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

- Services covered under "Reconstructive Surgery" in the "Benefits and Cost Sharing" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section: testicular implants implanted as part of a covered

reconstructive surgery, breast prostheses needed after a mastectomy, and prostheses to replace all or part of an external facial body part

Custodial care

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

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

Dental and orthodontic Services

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

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

Disposable supplies

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

This exclusion does not apply to disposable supplies covered under "Durable Medical Equipment for Home Use", "Home Health Care", "Hospice Care", "Ostomy and Urological Supplies", and "Outpatient Prescription Drugs,

Supplies, and Supplements" in the "Benefits and Cost Sharing" section.

Experimental or investigational Services

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

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

This exclusion does not apply to any of the following:

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

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

Hair loss or growth treatment

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

Infertility Services

Services related to the diagnosis and treatment of infertility.

Intermediate care

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

Items and services that are not health care items and services

For example, we do not cover:

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

Items and services to correct refractive defects of the eye

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

Massage therapy

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

Routine foot care items and services

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

Services not approved by the federal Food and Drug Administration

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

This exclusion does not apply to any of the following:

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

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

Services performed by unlicensed people

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

the services be provided by a licensed health care provider.

Services related to a noncovered Service

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

Transgender surgery

Travel and lodging expenses

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

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

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *Membership Agreement and Evidence of Coverage*, such as major disaster, epidemic, war,

riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes. Under these circumstances, if a Member has an Emergency Medical Condition, call **911** or go to the nearest hospital as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, and we will provide coverage and reimbursement as described in that section.

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

Reductions

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 a Member obtains a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which they 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 or the Member may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total of Charges for the relevant Services.

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

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

For Northern California Members:

Healthcare Recoveries, Inc.
Subrogation mailbox
9390 Bunsen Parkway
Louisville, KY 40220

For Southern California Members:

The Rawlings Group
Subrogation mailbox
PO Box 2000
LaGrange, KY 40031

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing the Member's 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 a Member's estate, parent, guardian, or conservator asserts a claim against a third party based on their 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 the Member had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

If a Member is 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

A Member's benefits are reduced by any benefits to which they are entitled under Medicare except for Members whose Medicare benefits are secondary by law.

Workers' compensation or employer's liability benefits

The Member 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 the Member is 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 the Member had diligently sought to establish their rights to the Financial Benefit under any workers' compensation or employer's liability law

Dispute Resolution

Grievances

We are committed to providing all Members with quality care and providing you 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 a Member received
- You received a written denial of Services that require prior authorization from the Medical Group or a "Notice of Non-Coverage" and you want us to cover the Services

- A Plan Physician has said that Services are not Medically Necessary and you want us to cover the Services
- You were told that Services are not covered and you believe that the Services should be covered
- The Member received care from a Non-Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services) and you want us to pay for the care
- We did not decide fully in your favor on a claim for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits and Cost Sharing" section and you want to appeal our decision
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility
- Health Plan has terminated your coverage and you believe your coverage has been terminated improperly
- We denied your membership application

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

- If we did not decide fully in your favor on a claim for Services described in the

"Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits and Cost Sharing" section and you want to appeal our decision, you can submit your grievance in one of the following ways:

- ♦ to the Claims Department at the following address:

For Northern California Members:
Kaiser Foundation Health Plan, Inc.
Special Services Unit
P.O. Box 23280
Oakland, CA 94623

For Southern California Members:
Kaiser Foundation Health Plan, Inc.
Special Services Unit
P.O. Box 7136
Pasadena, CA 91109

- ♦ by calling our Member Service Call Center at **1-800-464-4000** or **1-800-390-3510** (TTY users call **1-800-777-1370**)
- For all other issues, you can submit your grievance in one of the following ways:
 - ♦ to the Member Services Department at a Plan Facility (please refer to *Your Guidebook* for addresses)
 - ♦ by calling our Member Service Call Center at **1-800-464-4000** (TTY users call **1-800-777-1370**)
 - ♦ through our website at **kp.org**

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

dispute about whether a Service is Medically Necessary, or an experimental or investigational treatment.

Expedited grievance

A Member or their 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 the Member's 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.

The Member or the Member's 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 a Member's 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 the Member's medical records or physician opinions. When appropriate, we will request medical records from Plan Providers on the Member's 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 the Member's medical records. We will ask you to send or fax us a written authorization so that we can request the Member's 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:

- Member may file for themselves
- Member may appoint someone as their authorized representative by completing our

authorization form. Authorization forms are available from a local Member Services Department at a Plan Facility or by calling our Member Service Call Center. Member's completed authorization form must accompany the grievance

- You may file for the Member, except that Member must appoint you as their 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 the Member 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
- Member's 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 a Member has a grievance against their health plan, they 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 the Member. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet website **<http://www.hmohelp.ca.gov>** has complaint forms, IMR application forms and instructions online.

Independent Medical Review (IMR)

If a Member qualifies, they or their authorized representative may have the Member's 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 the Member. 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:
 - ♦ the Member has a recommendation from a provider requesting Medically Necessary Services

- ◆ the Member have received Emergency Services, emergency ambulance Services, or Urgent Care from a provider who determined the Services to be Medically Necessary
- ◆ the Member has been seen by a Plan Provider for the diagnosis or treatment of their 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 or the Member has 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 the Member 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:

- The Member's treating physician provided us a written statement that the Member has a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving the Member's 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 a Member's 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 the Member than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying his or her recommendation
- The Member (or their 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 the Member than any

available standard therapy. The physician’s certification included a statement of the evidence relied upon by the physician in certifying his or her recommendation. We do not cover the Services of the Non–Plan Provider

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

Binding Arbitration

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

Scope of arbitration

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

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *Membership Agreement and Evidence of Coverage* or a Member Party’s relationship to Kaiser Foundation Health Plan, Inc. (Health Plan), including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises

liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted

- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- The claim is *not* within the jurisdiction of the Small Claims Court

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

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

“Kaiser Permanente Parties” include:

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

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

Initiating arbitration

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

Serving Demand for Arbitration

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

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

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

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

Filing fee

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

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

Number of arbitrators

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (see the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator*).

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

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for 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. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a

Member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

A Member's membership termination date is the first day they are not covered (for example, if a Member's termination date is January 1, 2013, the last minute of coverage was at 11:59 p.m. on December 31, 2012). The Member will be billed as a non-Member for any Services they receive after your membership terminates. When your membership terminates, Health Plan and Plan Providers have no further liability or responsibility under this *Membership Agreement and Evidence of Coverage*, except as provided under "Payments after Termination" in this "Termination of Membership" section.

How You May Terminate Your Membership

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

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

Termination Due to Loss of Eligibility

If the Member meets 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 they no longer meet those eligibility requirements, their membership will end at 11:59 p.m. on the last day of that month. For example, the Member becomes ineligible on December 5, 2011, their termination date is January 1, 2012 and their last minute of coverage is at 11:59 p.m. on December 31, 2011.

You must provide all information requested by Health Plan to determine continuing eligibility for child(ren) enrolled in the Child Health Plan. You must notify Health Plan immediately of any changes in meeting any of the eligibility criteria specified in this *Agreement*, or any other changes to the member's account, such as name, address or phone number. These changes can be made using the Kaiser Permanente Membership Update form. Please call Member Services at **1-800-464-4000** to request a copy of this form.

Failure to provide such information or to meet the eligibility criteria will result in loss of eligibility.

Termination for Cause

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

- You intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider. Some examples of fraud include:
 - ♦ misrepresenting eligibility information

- ◆ 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 a Person's membership for cause, they 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

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

Termination for nonpayment of Premiums

If you do not pay the required Premiums by the due date, we may terminate membership as described in this "Termination for Nonpayment of Premiums" section. If you intend to terminate membership, be sure to notify us as described under "How You May Terminate Your Membership" in this "Termination of Membership" section, as you will be responsible for any Premiums billed to you prior to our receipt of your written notice.

The Premium payment for the upcoming coverage month is due on the first day of that month. If we do not receive full Premium payment on or before the first

day of the coverage month, we will send a notice of nonreceipt of payment (a "Late Notice") to your address of record. This Late Notice will include the following information:

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

If we terminate this *Membership Agreement and Evidence of Coverage* because we did not receive the required Premiums when due, a Person's membership will end at 11:59 p.m. on the 30th day after the date of the Late Notice. Coverage will continue during this 30 day grace period, but upon termination you will be responsible for paying all past due Premiums, including the Premiums for this grace period.

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

- A statement that we have terminated this *Membership Agreement and Evidence of Coverage* for nonpayment of Premiums
- The specific date and time when the memberships of the Member ended
- The amount of Premiums that are due
- Information explaining whether or not you can reinstate this *Membership Agreement and Evidence of Coverage*
- The Member's appeal rights

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

Reinstatement after termination for nonpayment of Premiums

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

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

Termination for Discontinuance of a Product

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

at least 180 days before the termination date.

Payments after Termination

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

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

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

State Review of Membership Termination

If you believe that we terminated a Member's membership because of ill health or their 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).

Conversion to another Individual Plan

When a Member's Child Health Plan membership ends, we will send a termination letter to the Applicant's address of record. The letter will include information about options that may be available to your child(ren) to remain a Health Plan Member.

Kaiser Permanente Conversion Plan

If your child(ren) wants to remain a Health Plan Member, one option that may be available is an individual plan called "Kaiser Permanente

Individual (Conversion) Plan.” The Premiums and coverage under our Individual (Conversion) Plan will differ from those under this *Agreement*. Your Child(ren) may be eligible to enroll in our Individual (Conversion) Plan if you they no longer meet the eligibility requirements described under “Who Is Eligible” in the “Premiums, Eligibility, and Enrollment” section.

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

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

A child who loses coverage for the Child Health Plan may not convert to our Individual (Conversion) Plan if we terminated the child’s membership under "Termination for Cause" or "Termination for nonpayment of Premiums".

Miscellaneous Provisions

Administration of this *Membership Agreement and Evidence of Coverage*

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

Advance directives

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

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

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

Membership Agreement and Evidence of Coverage binding on Members

By electing coverage or accepting benefits under this *Membership Agreement and Evidence of*

Coverage, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *Membership Agreement and Evidence of Coverage*.

Applications and statements

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

Assignment

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

Attorney and advocate fees and expenses

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

Claims review authority

We are responsible for determining whether you are entitled to benefits under this *Membership Agreement and Evidence of Coverage* and we have the discretionary authority to review and evaluate claims that arise under this *Membership Agreement and Evidence of Coverage*. We conduct this evaluation independently by interpreting the provisions of this *Membership Agreement and Evidence of Coverage*. If coverage under this *Membership Agreement and Evidence of Coverage* is subject to the Employee Retirement Income Security Act (ERISA)

claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *Membership Agreement and Evidence of Coverage*.

Governing law

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

Health Insurance Counseling and Advocacy Program (HICAP)

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

No waiver

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

Nondiscrimination

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

Notices

Our notices to you will be sent to the most recent address we have for you, the Applicant, except that if the Applicant has chosen to receive these membership agreement and evidence of coverage documents online we will notify the Applicant at the most recent email address we have for the Applicant when notices related to amendment of this *Membership Agreement and Evidence of Coverage* are posted on our website at **kp.org**. You are responsible for notifying us of any change in address. Applicants who move (or change their email address if the Applicant has chosen to receive these membership agreement and evidence of coverage documents on our Web site) 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 Applicant, the Applicant should contact our Member Service Call Center to discuss alternate delivery options.

Other formats for Members with disabilities

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

Overpayment recovery

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

Privacy practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to

protect your protected health information. Your protected health information is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information.

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

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

Public policy participation

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

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

Telephone access (TTY)

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

Helpful Information

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

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

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

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

How to Reach Us

Appointments

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

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

Website **kp.org** for routine (non-urgent) appointments with your personal Plan Physician or another Primary Care Physician

Not sure what kind of care you need?

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

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

Member Services

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

Call **1-800-464-4000**
1-800-777-1370 (TTY)

Weekdays 7 a.m. to 7 p.m.,
and weekends 7 a.m. to 3 p.m.
(except holidays)

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

Website **kp.org**

Authorization for Post-Stabilization Care

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

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

711 (TTY)

24 hours a day, seven days a week

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

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

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

Website **kp.org**

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

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

Write *For Northern California Members:*

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

For Southern California Members:

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

Payment Responsibility

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

- The Subscriber is responsible for paying Premiums (refer to "Premiums" in the "Premiums, Eligibility, and Enrollment" section)
- You are responsible for paying Cost Sharing for covered Services (refer to "Cost Sharing" in the "Benefits and Cost Sharing" section)
- If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non-Plan Provider, or if you receive

emergency ambulance Services, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us (refer to "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)

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



Member Service Call Center

1-800-464-4000

1-800-777-1370 (TTY for the deaf, hard of hearing, or speech impaired)

Weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays)

kp.org

info.kp.org/childhealthplan