Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation

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

$500 Deductible Plan

<table>
<thead>
<tr>
<th>Highlights</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible for certain Services</td>
<td>$500 per calendar year for one Member and $1,000 for a Family Unit</td>
</tr>
<tr>
<td><strong>Copayments after Deductible is met:</strong></td>
<td></td>
</tr>
<tr>
<td>Most office visits</td>
<td>$20 per visit (Deductible doesn't apply)</td>
</tr>
<tr>
<td>Hospital inpatient care</td>
<td>$100 per day after Deductible</td>
</tr>
<tr>
<td>Outpatient surgery</td>
<td>$50 per procedure after Deductible</td>
</tr>
<tr>
<td>Emergency Department visits</td>
<td>$100 per visit after Deductible</td>
</tr>
<tr>
<td>Generic drugs</td>
<td>$10 for up to a 30-day supply (Deductible doesn't apply)</td>
</tr>
<tr>
<td>Brand name drugs</td>
<td>$35 for up to a 30-day supply (Deductible doesn't apply)</td>
</tr>
</tbody>
</table>

*January 1, 2008, through December 31, 2008*

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

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

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

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

- **For self-only enrollment (a Family Unit of one Member)**: $2,500 per calendar year
- **For any one Member in a Family Unit of two or more Members**: $2,500 per calendar year
- **For an entire Family Unit of two or more Members**: $5,000 per calendar year

## Deductible for Certain Services as specified below

You must pay Charges for Services you receive in a calendar year until you reach one of the following Deductible amounts:

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

## Lifetime Maximum

None

## Professional Services (Plan Provider office visits)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary and specialty care visits (includes routine and Urgent Care appointments)</td>
<td>$20 per visit (Deductible doesn't apply)</td>
</tr>
<tr>
<td>Routine preventive physical exams</td>
<td>$20 per visit (Deductible doesn't apply)</td>
</tr>
<tr>
<td>Well-child preventive care visits (0–23 months)</td>
<td>No charge (Deductible doesn't apply)</td>
</tr>
<tr>
<td>Family planning visits</td>
<td>$20 per visit (Deductible doesn't apply)</td>
</tr>
<tr>
<td>Scheduled prenatal care and first postpartum visit</td>
<td>No charge (Deductible doesn't apply)</td>
</tr>
<tr>
<td>Voluntary termination of pregnancy</td>
<td>$20 per procedure after Deductible</td>
</tr>
<tr>
<td>Routine preventive refraction exams</td>
<td>$20 per visit (Deductible doesn't apply)</td>
</tr>
<tr>
<td>Routine preventive hearing tests</td>
<td>$20 per visit (Deductible doesn't apply)</td>
</tr>
<tr>
<td>Physical, occupational, and speech therapy visits</td>
<td>$20 per visit after Deductible</td>
</tr>
</tbody>
</table>

## Outpatient Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient surgery</td>
<td>$50 per procedure after Deductible</td>
</tr>
<tr>
<td>Allergy injection visits</td>
<td>$5 per visit after Deductible</td>
</tr>
<tr>
<td>Allergy testing visits</td>
<td>$20 per visit (Deductible doesn't apply)</td>
</tr>
<tr>
<td>Vaccines (immunizations)</td>
<td>No charge (Deductible doesn't apply)</td>
</tr>
<tr>
<td>X-rays and lab tests</td>
<td>$10 per encounter after Deductible (except the Deductible doesn't apply to preventive screenings as described in the &quot;Benefits and Cost Sharing&quot; section)</td>
</tr>
</tbody>
</table>

Health education:
- Individual visits: $20 per visit (Deductible doesn't apply)
- Group educational programs: No charge (Deductible doesn't apply)

## Hospitalization Services

<table>
<thead>
<tr>
<th>Hospitalization Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and board, surgery, anesthesia, X-rays, lab tests, and drugs</td>
<td>$100 per day after Deductible</td>
</tr>
</tbody>
</table>

## Emergency Health Coverage

<table>
<thead>
<tr>
<th>Emergency Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department visits</td>
<td>$100 per visit after Deductible</td>
</tr>
</tbody>
</table>

## Ambulance Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services</td>
<td>$150 per trip after Deductible</td>
</tr>
<tr>
<td>Prescription Drug Coverage</td>
<td>You Pay</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>Most covered outpatient items in accord with our drug formulary guidelines:</td>
<td></td>
</tr>
<tr>
<td>Generic items from a Plan Pharmacy</td>
<td>$10 for up to a 30-day supply, $20 for a 31 to 60-day supply, or $30 for a 61 to 100-day supply (Deductible doesn't apply)</td>
</tr>
<tr>
<td>Generic refills from our mail-order program</td>
<td>$10 for up to a 30-day supply or $20 for a 31 to 100-day supply (Deductible doesn't apply)</td>
</tr>
<tr>
<td>Brand-name items from a Plan Pharmacy</td>
<td>$35 for up to a 30-day supply, $70 for a 31 to 60-day supply, or $105 for a 61 to 100-day supply (Deductible doesn't apply)</td>
</tr>
<tr>
<td>Brand-name refills from our mail-order program</td>
<td>$35 for up to a 30-day supply or $70 for a 31 to 100-day supply (Deductible doesn't apply)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Durable Medical Equipment (DME)</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most covered DME for home use in accord with our DME formulary guidelines up to a $2,000 calendar year benefit limit as described in the &quot;Benefits and Cost Sharing&quot; section</td>
<td>20% Coinsurance (Deductible doesn't apply)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mental Health Services</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient psychiatric care (up to 30 days per calendar year)</td>
<td>$100 per day after Deductible</td>
</tr>
<tr>
<td>Outpatient visits:</td>
<td></td>
</tr>
<tr>
<td>Up to a total of 20 individual and group visits per calendar year</td>
<td>$20 per individual visit (Deductible doesn't apply) $10 per group visit (Deductible doesn't apply)</td>
</tr>
<tr>
<td>Up to 20 additional group visits that meet the Medical Group criteria in the same calendar year</td>
<td>$10 per group visit (Deductible doesn't apply)</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Chemical Dependency Services</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient detoxification</td>
<td>$100 per day after Deductible</td>
</tr>
<tr>
<td>Outpatient individual visits</td>
<td>$20 per visit (Deductible doesn't apply)</td>
</tr>
<tr>
<td>Outpatient group visits</td>
<td>$5 per visit (Deductible doesn't apply)</td>
</tr>
<tr>
<td>Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)</td>
<td>$100 per admission after Deductible</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Health Services</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care (up to 100 visits per calendar year)</td>
<td>No charge (Deductible doesn't apply)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled Nursing Facility care (up to 100 days per benefit period)</td>
<td>No charge after Deductible</td>
</tr>
<tr>
<td>Hospice care</td>
<td>No charge (Deductible doesn't apply)</td>
</tr>
</tbody>
</table>

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 Individual Plan Membership Agreement and Disclosure Form and Evidence of Coverage (Agreement) and any amendments describe the health care coverage of "Kaiser Permanente For Individuals and Families" (which is not a federally qualified health benefit plan). It constitutes the legally binding contract between Health Plan (Kaiser Foundation Health Plan, Inc.) and you (the Subscriber). For benefits provided under any other Health Plan program, refer to that plan's evidence of coverage.

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

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

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

Term of this Agreement, Renewal, and Amendment

Term of this Agreement

This Agreement is effective from January 1, 2008 (or your membership effective date, if later), through December 31, 2008, unless this Agreement is:

- Revised under "Amendment of Agreement" below
- Terminated under the "Termination of Membership" section
- Rescinded under the "Rescission of Membership" section

Renewal

If you comply with all of the terms of this Agreement, we will offer to renew this Agreement effective January 1, 2009, upon 30 days prior written notice to the Subscriber (we will send the notice by e-mail if the Subscriber has opted to receive these agreements on our Web site at kp.org). We will either send the Subscriber a new agreement (or post the new agreement on our Web site if the Subscriber has opted to receive these agreements online) to become effective immediately after termination of this Agreement, or we will extend the term of this Agreement pursuant to "Amendment of Agreement." The new or extended agreement will include a new term of agreement and other changes. If you do not want to renew this Agreement, you must give us written notice as described under "How You May Terminate Your Membership" in the "Termination of Membership" section.

Amendment of Agreement

We may amend this Agreement at any time by sending written notice to the Subscriber at least 30 days before the effective date of the amendment (we will send the notice by e-mail if the Subscriber has opted to receive these agreements on our Web site at kp.org). All such amendments are deemed accepted by the Subscriber unless the Subscriber gives us written notice of non-acceptance within 30 days of the date of the notice, in which case this Agreement terminates the day before the effective date of the amendment.

If we notified the Subscriber that we have not received all necessary governmental approvals related to this Agreement, we may amend this Agreement by giving written notice to the Subscriber after receiving all necessary governmental approval (we will send the notice by e-mail if the Subscriber has opted to receive these agreements on our Web site at kp.org). Any such government-approved provisions go into effect on January 1, 2008 (unless the government requires a later effective date).

About Kaiser Permanente

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

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:
• Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Cost Sharing" section
• Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency, Post-stabilization, and Out-of-Area Urgent Care from Non–Plan Providers" section
• Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
• Hospice care as described under "Hospice Care" in the "Benefits and Cost Sharing" section

Definitions

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

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

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

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

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

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

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

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

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

Emergency Medical Condition: An Emergency Medical Condition is: (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs; or (2) active labor when there isn't enough time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety.

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

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

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and the Medical Group.
Medical Group: The Permanente Medical Group, Inc., a for-profit professional corporation.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Post-stabilization Care: Post-stabilization Care is Medically Necessary Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable.

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

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

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

• Amador: 95640, 95669
• El Dorado: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95672, 95682, 95762
convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

**Spouse:** Your legal husband or wife. For the purposes of this Agreement, the term "Spouse" includes your registered domestic partner who meets all of the requirements of Section 297 of the California Family Code, or your domestic partner as determined by Health Plan.

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

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

### Premiums, Eligibility, and Enrollment

#### Premiums

You must prepay the Premiums listed on the enclosed rate sheet, applicable to your coverage, for each month on or before the last day of the preceding month. Your Premiums may change if you add Dependents, drop Dependents, or move to a new rate area. Only Members for whom we have received the appropriate Premiums are entitled to coverage under this Agreement, 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 Unit by the total number of Members enrolled in our Northern California Region.

### Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Who Is Eligible" section. In addition, you must pass our medical review to enroll.
Service Area eligibility requirements

The Subscriber must live in our Service Area at the time he or she enrolls. The "Definitions" section describes our Service Area and how it may change. You cannot enroll or continue enrollment as a Subscriber or Dependent if you live in or move to a Region outside California except for your Dependent children. If you move anywhere else outside our Service Area after enrollment, you can continue your membership as long as you meet all other eligibility requirements. However, you must receive covered Services from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

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

Regions outside California. If you live in or move to the service area of a Region outside California, you are not eligible for membership under this Agreement. However, this restriction does not apply if you are a Dependent child of the Subscriber or the Subscriber's Spouse (see "Visiting Other Regions" in the "How to Obtain Services" section for information about obtaining care when you are temporarily in another service area). You may be able to apply for membership in the other service area by contacting the member or customer service department there, but the coverage, premiums, and eligibility requirements might not be the same.

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

Southern California Region's service area. If you live in or are moving to our Southern California Region’s service area, you may be able to apply for membership in that Region. However, the coverage and eligibility requirements might not be the same as under this Agreement. To apply for Individual Plan membership in our Southern California Region, please call our Member Service Call Center.

Additional eligibility requirements

If you are a Subscriber, the following persons are eligible to enroll as your Dependents:

- Your Spouse
- Your or your Spouse's unmarried children (including adopted children or children placed with you for adoption) who are under age 19
- Other unmarried dependent persons (but not including foster children) who meet all of the following requirements:
  - they are under age 19
  - they receive all of their support and maintenance from you or your Spouse
  - they permanently reside with you (the Subscriber)
  - you or your Spouse is the court-appointed guardian (or was before the person reached age 18) or the person's parent is an enrolled Dependent under your family coverage

- Dependents who meet the Dependent eligibility requirements, except for the age limit, may be eligible if they meet all of the following requirements:
  - they are incapable of self-sustaining employment because of mental retardation or physical handicap that occurred prior to age 19
  - they receive substantially all of their support and maintenance from you or your Spouse
  - you give us proof of their incapacity and dependency within 31 days after we request it

Persons barred from enrolling

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

Members with Medicare

This plan is not intended for most Medicare beneficiaries. If, during the term of this Agreement, you are or become eligible for Medicare (please see "Medicare" in the "Definitions" section for the meaning of "eligible for" Medicare) you may enroll in Kaiser Permanente Senior Advantage.
Medicare late enrollment penalty. If you become eligible for Medicare Part B or D and do not enroll during the initial Medicare enrollment period, Medicare may require you to pay a late enrollment penalty if you later enroll in Medicare Part B or a Medicare Part D plan. In the case of Medicare Part D, the late enrollment penalty may apply if you go 63 days or longer without Medicare Part D creditable prescription drug coverage, which means prescription drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage. This Medicare Part D late enrollment penalty applies as long as you have Medicare Part D prescription drug coverage. The amount of the penalty may increase every year. If you are or become eligible for Medicare Part D, we will send you a notice that tells you whether your drug coverage under this Agreement is Medicare Part D creditable drug coverage at the times required by CMS and upon request. For more information, contact our Member Service Call Center.

How to Enroll

To request enrollment, you must submit a Health Plan application and medical review form for each Member of your Family Unit. Each person listed on the application form must submit medical review information. If you are already enrolled as a Subscriber, the same procedure applies if you request enrollment of Dependents, except that you do not need to send a medical review form when requesting enrollment of a newborn or newly adopted child if you submit a Health Plan change of enrollment form within 31 days of birth, or of the date you gain the legal right to control the adopted child's health care.

Note: Medical review considers the health information you provide in your enrollment application. If we determine that you or someone on your behalf intentionally provided incomplete or incorrect material information about your current or past health in your enrollment application or during the enrollment process, we may rescind your membership (completely void your membership so that no coverage ever existed). You will have to pay as a non-Member for any Services we provided or covered. Please refer to the "Rescission of Membership" section for details.

Selecting and switching your benefit plan

When you enroll in one of our plans for individuals and families, the Subscriber must select a plan for your entire Family Unit. At any time after your enrollment effective date, you may apply to switch to another Kaiser Permanente for Individuals and Families plan. You do not have to pass medical review to switch to a plan that is lower on the following list than your current plan, but you must pass medical review to switch to a plan that is higher on the list than your current plan:

- $25 Copayment Plan
- $500 Deductible Plan
- $1,000 Deductible Plan
- $50 Copayment Plan
- $1,500 Deductible Plan
- $0/$1,500 Deductible Plan with HSA
- $0/$2,700 Deductible Plan with HSA
- $30/$2,700 Deductible Plan with HSA

Please contact our Member Service Call Center to request an application to switch your plan or for more information on the hierarchy of our plan offerings including any plans that we began offering since this EOC was printed that are not listed above.

Effective date of coverage

If we approve your enrollment application, we will notify you of the date your coverage will begin (membership begins at the beginning [12:00 a.m.] of the effective date specified in our notice). Other than a newborn or a newly adopted child (including a child placed with you for adoption), the effective date will be either the first of the month following the date when we approve your application, or the first of the month after that. When you add a newborn or a newly adopted child to your Family Unit, the effective date of coverage is as follows:

- A newborn child is covered from the moment of birth if the Subscriber enrolls the child within 31 days after birth. Any Premiums required for the newborn will be effective the first of the month following birth
- If the newborn child is not enrolled within 31 days, the newborn is covered only through the calendar month of birth, or the mother's hospitalization if she is a Member, whichever is later
- The membership of a newly adopted child (including a child placed with you for adoption) will begin on the date when the adopting parent gains the legal right to control the child's health care if the Subscriber enrolls the child within 31 days of that date
How to Obtain Services

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

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

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

Your Primary Care Plan Physician

Your primary care Plan Physician plays an important role in coordinating your medical care needs, including hospital stays and referrals to specialists. We encourage you to choose a primary care Plan Physician. You may select a primary care Plan Physician from any of our available Plan Physicians who practice in these specialties: internal medicine, family medicine, and pediatrics. Also, women can select any available primary care Plan Physician from obstetrics/gynecology. You can change your primary care Plan Physician for any reason. To learn how to select a primary care Plan Physician, please call our Member Service Call Center. You can find a directory of our Plan Physicians on our Web site at kp.org.

Routine Care

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

Urgent Care

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

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

Our Advice Nurses

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

Getting a Referral

Referrals to Plan Providers

Primary care. Primary care Plan Physicians provide primary medical care, including pediatric care and obstetrics/gynecology care. You don't need a referral to receive primary care from Plan Physicians in the following areas: internal medicine, family medicine, obstetrics/gynecology, family planning, and pediatrics.

Specialty care. Plan Physicians who are specialists provide specialty care in areas such as surgery, orthopedics, cardiology, oncology, urology, and dermatology. A Plan Physician must refer you before you can be seen by one of our specialists except that you do not need a referral to receive care in the following areas: optometry, psychiatry, and chemical dependency. Please check Your Guidebook to see if your facility has other departments that don't require a referral.
Medical Group authorization procedure for certain referrals

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

- **Services not available from Plan Providers.** If your Plan Physician decides that you require covered Services not available from Plan Providers, he or she will recommend to the Medical Group that you be referred to a Non-Plan Provider inside or outside our Service Area. The appropriate Medical Group designee will authorize the Services if he or she determines that they are Medically Necessary and are not available from a Plan Provider. Referrals to Non-Plan Physicians will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your Plan Physician what Services have been authorized.

- **Durable medical equipment (DME).** If your Plan Physician prescribes a DME item, he or she will submit a written referral to the Plan Hospital's DME coordinator, who will authorize the DME item if he or she determines that your DME coverage includes the item and that the item is listed on our formulary for your condition. If the item doesn't appear to meet our DME formulary guidelines, then the DME coordinator will contact the Plan Physician for additional information. If the DME request still doesn't appear to meet our DME 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 DME formulary, please refer to "Durable Medical Equipment for Home Use" in the "Benefits and Cost Sharing" section.

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

- **Transplants.** If your Plan Physician makes a written referral for a transplant, the Medical Group's regional transplant advisory committee or board (if one exists) will authorize the Services if it determines that they are Medically Necessary. In cases where no transplant committee or board exists, the Medical Group will refer you to physician(s) at a transplant center, and the Medical Group will authorize the Services if the transplant center’s physician(s) determine that they are Medically Necessary. Note: A Plan Physician may provide or authorize a corneal transplant without using this Medical Group transplant authorization procedure.

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

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

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

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

Second Opinions

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

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

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

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

Contracts with Plan Providers

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

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

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

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

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

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends
- We may cover Services for serious chronic conditions until the earlier of (i) 12 months from the termination date of the terminated provider, or (ii) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non-Plan Provider and
consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:

- it persists without full cure
- it worsens over an extended period of time
- it requires ongoing treatment to maintain remission or prevent deterioration

- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Care for children under age 3. We may cover completion of these Services until the earlier of (i) 12 months from the termination date of the terminated provider, or (ii) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of the termination date of the terminated provider

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

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

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

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

**Visiting Other Regions**

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

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

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

**Your Identification Card**

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

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

**Getting Assistance**

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your primary care Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.
Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Call Center representatives are available to assist you weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays) toll free at 1-800-464-4000 or 1-800-777-1370 (TTY for the deaf, hard of hearing, or speech impaired). For your convenience, you can also contact us through our Web site at kp.org.

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

**Plan Facilities**

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

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

**Plan Hospitals and Plan Medical Offices**

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

**Alameda**
- Medical Offices: 2417 Central Ave.

**Antioch**
- Hospital and Medical Offices: 5601 Deer Valley 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
- Medical Offices: 3800 Dale Rd. and 4601 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.

Pleasanton
- Medical Offices: 7601 Stoneridge Dr.

Rancho Cordova
- Medical Offices: 10725 International Dr.

Redwood City
- Hospital and Medical Offices: 1150 Veterans Blvd.

Richmond
- Hospital and Medical Offices: 901 Nevin Ave.

Rohnert Park
- Medical Offices: 5900 State Farm Dr.

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

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

San Bruno
- Medical Offices: 901 El Camino Real

San Francisco
- Hospital and Medical Offices: 2425 Geary Blvd.

San Jose
- Hospital and Medical Offices: 250 Hospital Pkwy.

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

Santa Clara
- Hospital and Medical Offices: 710 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
- Medical Offices: 3700 Vaca Valley Pkwy.

Vallejo
- Hospital and Medical Offices: 975 Sereno Dr.

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

Your Guidebook to Kaiser Permanente Services

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 calling our Member Service Call Center or by visiting our Web site at kp.org.

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

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

Emergency, Post-stabilization, and Out-of-Area Urgent Care from Non-Plan Providers

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

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

For example, we will not cover non-Plan Skilled Nursing Facility care as part of authorized Post-stabilization Care unless both of the following are true:
- This "Emergency, Post-stabilization, and Out-of-Area Urgent Care from Non–Plan Providers" section says that we cover the care (we authorize the care and the care meets the definition of "Post-stabilization Care")
- The care would be covered under "Skilled Nursing Facility Care" in the "Benefits and Cost Sharing" section (subject to the "Exclusions, Limitations, and Reductions" section) if you received the care from a Plan Skilled Nursing Facility inside our Service Area

Prior Authorization

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

Emergency Care

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

An Emergency Medical Condition is: (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs; or (2) active labor when there isn’t enough time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child’s) health and safety.

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

Post-stabilization Care

Post-stabilization Care is the Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable. We cover Post-stabilization Care from a Non–Plan Provider, including
inpatient care at a Non–Plan Hospital, only if we provide prior authorization for the care.

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

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

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

**Out-of-Area Urgent Care**

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

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

**Follow-up Care**

We do not cover follow-up care provided by Non–Plan Providers unless it is covered Emergency Care, Post-stabilization Care, or Out-of-Area Urgent Care described in this "Emergency, Post-stabilization, and Out-of-Area Urgent Care from Non–Plan Providers" section.

**Payment and Reimbursement**

If you receive Emergency Care, Post-stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. Also, you may be required to pay and file a claim for any Services prescribed by a Non–Plan Provider in conjunction with covered Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy. To request payment or reimbursement, you must file a claim as described under "Requests for Payment" in the "Requests for Payment or Services" section.

**Cost Sharing**

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

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

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

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

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

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

- The "Emergency, Post-stabilization, and Out-of-Area Urgent Care from Non–Plan Providers" section for information about how to obtain covered Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care from Non–Plan Providers

Your Guidebook for the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services

Cost Sharing (Deductibles, Copayments, and Coinsurance)

At the time you receive covered Services, you must pay your Cost Sharing amounts as described in this "Benefits and Cost Sharing" section. If you receive more than one Service from a provider, or Services from more than one provider, you may be required to pay separate Cost Sharing amounts for each Service and each provider. For example, if you receive Services from two specialists in one visit, you may have to pay the Cost Sharing for two specialist visits. Similarly, if your physician performs a procedure immediately after a consultation, you may have to pay separate Cost Sharing amounts for the consultation visit and for the procedure. If you have questions about Cost Sharing, please contact our Member Service Call Center.

In some cases, we may agree to bill you for your Cost Sharing amount.

Deductibles

In any calendar year, you must pay Charges for certain Services until you meet one of the following Deductible amounts:

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

If you are a Member in a Family Unit of two or more Members, you reach the Deductible either when you meet the amount for any one Member, or when your entire Family Unit reaches the Family Unit amount. For example, suppose you have reached the Deductible of $500. For Services subject to the Deductible, you will not pay Charges during rest of the calendar year, but each other Member in your Family Unit must continue to pay Charges during the calendar year until the entire Family Unit reaches the Deductible of $1,000.

After you meet the Deductible and for the remainder of the calendar year, you pay the applicable Copayment or Coinsurance subject to the limits described under "Annual out-of-pocket maximum" in this "Benefits and Cost Sharing" section.
Services that are subject to the Deductible. All covered Services are subject to this Deductible, except for those covered in the "Outpatient Prescription Drugs, Supplies, and Supplements" section and those that are listed as not subject to the Deductible in this "Benefits and Cost Sharing" section.

When Services are subject to a Deductible and you have not met the Deductible, you must pay Charges for the Services you are scheduled to receive when you check in for an appointment or procedure.

If you would like an estimate of the Charges for a Service before you schedule an appointment or procedure, please go to our Web site at kp.org or call our Deductible Products Service Team toll free at 1-800-390-3507. Note: If you pay a Deductible amount for a Service that has a visit limit, the Services count towards reaching the limit.

After you receive the Services, we will compare the Charges for the Services subject to the Deductible that you actually received against what you paid when you checked in for an appointment or procedure. If you overpaid, we will send you a refund promptly. If you underpaid, we will bill you.

Keeping track of the Deductible. When you pay an amount toward your Deductible, we will give you a receipt and we will send you a statement. The statement will include the total amount you have paid toward your Deductible. You can also obtain a copy of this statement from our Deductible Products Service Team toll free at 1-800-390-3507. Any overpayments will be refunded to you promptly.

Copayments and Coinsurance
The Copayment or Coinsurance you must pay for each covered Service (after you meet any applicable Deductible) is described in this "Benefits and Cost Sharing" section. Cost Sharing is due at the time you receive the Services, except for the following:

- For items ordered in advance, you pay the Cost Sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Sharing before the item is ordered

Annual out-of-pocket maximum
There is a limit to the total amount of Cost Sharing you must pay under this Agreement in a calendar year for all of the covered Services listed below that you receive in the same calendar year. The limit is one of the following amounts:

- $2,500 per calendar year for self-only enrollment (a Family Unit of one Member)
- $2,500 per calendar year for any one Member in a Family Unit of two or more Members
- $5,000 per calendar year for an entire Family Unit of two or more Members

If you are a Member in a Family Unit of two or more Members, you reach the annual out-of-pocket maximum either when you meet the maximum for any one Member, or when your Family Unit reaches the Family Unit maximum. For example, suppose you have reached the $2,500 maximum. For Services subject to the maximum, you will not pay any more Cost Sharing during the rest of the calendar year, but each other Member in your Family Unit must continue to pay Cost Sharing during the calendar year until your Family Unit reaches the maximum of $5,000.

Payments that count toward the maximum. Any amounts you pay for covered Services subject to the Deductible, as described under "Deductibles," apply toward the annual out-of-pocket maximum. Also, the Copayments and Coincurrence you pay for the following Services apply toward the annual out-of-pocket maximum:

- Ambulance Services
- Amino acid-modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)
- Diabetic testing supplies and equipment and insulin-administration devices
- Emergency Department visits
- Home health care
- Hospice care
- Hospital care, except that for mental health hospital care, the only care that counts is care for these mental health conditions:
  ♦ Serious Emotional Disturbances (SED) of a child described under "Mental Health Services" in this "Benefits and Cost Sharing" section
  ♦ these severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa
- Imaging, laboratory, and special procedures
- Office visits (including professional Services such as dialysis treatment, health education, and physical, occupational, and speech therapy). However,
Deductible.

- Serious Emotional Disturbances (SED) of a child described under "Mental Health Services" in this "Benefits and Cost Sharing" section
- these severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa

- Outpatient surgery
- Prosthetic and orthotic devices

**Keeping track of the maximum.** When you pay a Cost Sharing amount for a Service that applies toward the annual out-of-pocket maximum, we will give you a receipt. We will also send you a statement summarizing the amounts you have paid toward your annual out-of-pocket maximum. You can also obtain a copy of this statement from our Deductible Products Service Team toll free at 1-800-390-3507.

**Preventive Care Services**

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

The preventive care Services listed below are not subject to the Deductible, unless the Services are intended to diagnose or treat an existing illness, injury, or condition that has already been diagnosed or for which you have symptoms. **Any other Services you receive during a preventive care exam will be subject to the Deductible.**

The following preventive care is exempt from the Deductible:

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

**Outpatient Care**

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

- Primary and specialty care visits: **a $20 Copayment per visit (not subject to the Deductible), except for the following:**
  - well-child preventive care visits (0–23 months): **no charge (not subject to the Deductible)**
  - after confirmation of pregnancy, the normal series of regularly scheduled preventive care prenatal visits and the first postpartum visit: **no charge (not subject to the Deductible)**
  - allergy injection visits: **a $5 Copayment per visit subject to the Deductible**

- Routine preventive physical exams, including well-woman visits: **a $20 Copayment per visit (not subject to the Deductible)**

- Routine preventive hearing tests to determine the need for hearing correction: **a $20 Copayment per visit (not subject to the Deductible)**

- Routine preventive refraction exams to determine the need for vision correction and to provide a prescription for eyeglass lenses: **a $20 Copayment per visit (not subject to the Deductible)**

- Up to two Medically Necessary contact lenses, fitting, and dispensing per eye every 12 months (including lenses we covered under any other evidence of coverage) to treat aniridia (missing iris): **no charge (not subject to the Deductible)**

- Up to six Medically Necessary aphakic contact lenses, fitting, and dispensing per eye per calendar
year (including lenses we covered under any other evidence of coverage) to treat aphakia (absence of the crystalline lens of the eye) for children from birth through age 9: **no charge (not subject to the Deductible)**

- Family planning visits for counseling, or to obtain emergency contraceptive pills, injectable contraceptives, internally implanted time-release contraceptives, or intrauterine devices (IUDs): **a $20 Copayment per visit (not subject to the Deductible)**

- Outpatient surgery: **a $50 Copayment per procedure subject to the Deductible** if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room; or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Any other outpatient surgery is covered at **a $20 Copayment per procedure (not subject to the Deductible)**

- Outpatient procedures (other than surgery): **a $50 Copayment per procedure subject to the Deductible** (except flexible sigmoidoscopies are **not subject to the Deductible**) if a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Any other outpatient procedures are covered **at the Cost Sharing that would otherwise apply**

- Voluntary termination of pregnancy: **a $20 Copayment per procedure subject to the Deductible**

- Physical, occupational, and speech therapy: **a $20 Copayment per visit subject to the Deductible**

- Physical, occupational, and speech therapy provided in our organized, multidisciplinary rehabilitation day-treatment program: **a $20 Copayment per day subject to the Deductible**

- Emergency Department visits: **a $100 Copayment per visit subject to the Deductible**

- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge (not subject to the Deductible)**

- Blood, blood products, and their administration: **no charge subject to the Deductible**

- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in a Plan Medical Office or during home visits: **no charge (not subject to the Deductible)**

- Vaccines (immunizations) approved for use by the federal Food and Drug Administration (FDA) and administered to you in a Plan Medical Office: **no charge (not subject to the Deductible)**

- Some types of outpatient visits may be available as group appointments, which are covered at **a $10 Copayment per visit (not subject to the Deductible)**

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

- Chemical Dependency Services
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Durable Medical Equipment for Home Use
- Health Education
- 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

**Hospital Inpatient Care**

We cover the following inpatient Services at **a $100 Copayment per day subject to the Deductible** in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals inside our Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists
Anesthesia

Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, please refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section)

Radioactive materials used for therapeutic purposes

Durable medical equipment and medical supplies

Imaging, laboratory, and special procedures

Blood, blood products, and their administration

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

Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation program)

Respiratory therapy

Medical social services and discharge planning

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

- Chemical Dependency Services
- Dental Services for Radiation Treatment and Dental Anesthesia
- 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**

When you have an Emergency Medical Condition, we cover emergency Services of a licensed ambulance anywhere in the world at a $150 Copayment per trip subject to the Deductible. In accord with the "Emergency, Post-stabilization, and Out-of-Area Urgent Care from Non–Plan Providers" section, we cover emergency ambulance Services that are not ordered by us only if one of the following is true:

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

**Nonemergency**

Inside our Service Area, we cover nonemergency ambulance and psychiatric transport van Services at a $150 Copayment per trip subject to the Deductible if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services.

**Ambulance Services exclusion**

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

**Chemical Dependency Services**

**Inpatient detoxification**

We cover hospitalization at a $100 Copayment per day subject to the Deductible in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

**Outpatient chemical dependency care**

We cover the following Services for treatment of chemical dependency:

- Day-treatment programs (each day in a day-treatment program counts as one visit)
- Intensive outpatient programs (each day in an intensive outpatient program counts as one visit)
- Individual and group chemical dependency counseling visits
- Visits for the purpose of medical treatment for withdrawal symptoms

You pay the following for these covered Services:

- Individual visits: a $20 Copayment per visit (not subject to the Deductible)
• Group visits: a $5 Copayment per visit (not subject to the Deductible)

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

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

Note: The following Services are not covered under this "Chemical Dependency Services" section:
- Outpatient laboratory Services (instead, refer to "Outpatient Imaging, Laboratory, and Special Procedures" in this "Benefits and Cost Sharing" section)
- Outpatient self-administered drugs (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section)

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

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

**Dental Services for radiation treatment**
We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck at a $20 Copayment per visit (not subject to the Deductible) if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

**Dental anesthesia**
For dental procedures at a Plan Facility, we provide general anesthesia and the facility's Services associated with the anesthesia if all of the following are true:
- You are under age 7, or you are developmentally disabled, or your health is compromised
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
- The dental procedure would not ordinarily require general anesthesia

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

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

Note: Outpatient prescription drugs are not covered under this "Dental Services for Radiation Treatment and Dental Anesthesia" section (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section).

**Dialysis Care**
If the following criteria are met, we cover dialysis Services related to acute renal failure and end-stage renal disease:
- The Services are provided inside our Service Area
- You satisfy all medical criteria developed by the Medical Group and by the facility providing the dialysis
- A Plan Physician provides a written referral for care at the facility

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

You pay the following for these covered Services related to dialysis:
- Inpatient dialysis care: a $100 Copayment per day subject to the Deductible
- One routine office visit per month with the multidisciplinary nephrology team: no charge (not subject to the Deductible)
- All other office visits: a $20 Copayment per visit (not subject to the Deductible)
• Hemodialysis treatment: a $20 Copayment per visit subject to the Deductible

Note: The following Services are not covered under this "Dialysis Care" section:
• Laboratory Services (instead, refer to "Outpatient Imaging, Laboratory, and Special Procedures" in this "Benefits and Cost Sharing" section)
• Outpatient prescription drugs (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section)
• Outpatient administered drugs (instead, refer to "Outpatient Care" in this "Benefits and Cost Sharing" section)

**Durable Medical Equipment for Home Use**

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

Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered DME, including repair and replacement of covered DME, is covered at 20% Coinsurance (not subject to the Deductible) up to the calendar year benefit limit described below except that external sexual dysfunction devices are covered at 50% Coinsurance (not subject to the Deductible).

We decide whether to rent or purchase the equipment, and we select the vendor. We will repair or replace the equipment, unless the repair or replacement is due to loss or misuse. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

**DME items 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:
• For diabetes blood testing, 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

**Calendar year benefit limit**
For most covered DME items, including repair and replacement of covered DME, there is a benefit limit of $2,000 per Member per calendar year. The benefit limit is calculated by adding up the Charges for the DME items we cover in a calendar year that are subject to the limit (including any of these items we covered under any other evidence of coverage, whether or not the other evidence of coverage had a benefit limit), less the Cost Sharing you paid for those items. If you reach the $2,000 benefit limit, we will not cover any more DME items in that calendar year if they are subject to the benefit limit.

The following items are not subject to this benefit limit:
• For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
• Infusion pumps (such as insulin pumps) and supplies to operate the pump
• Standard curved handle or quad cane and replacement supplies
• Standard or forearm crutches and replacement supplies
• Dry pressure pad for a mattress
• Nebulizer and supplies
• Peak flow meters
• IV pole
• Tracheostomy tube and supplies
• Enteral pump and supplies
• Bone stimulator
• Cervical traction (over door)

**Outside the Service Area**
We do not cover most DME for home use outside our Service Area. However, if you live outside our Service Area, we cover the following DME items (subject to the Cost Sharing and all other coverage requirements that apply to DME for home use inside our Service Area) when the item is dispensed at a Plan Facility:
• Standard curved handle cane
• Standard crutches
• For diabetes blood testing, blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
• Insulin pumps and supplies to operate the pump (but not including insulin or any other drugs), after completion of training and education on the use of the pump
• Nebulizers and their supplies for the treatment of pediatric asthma
• Peak flow meters from a Plan Pharmacy

About our DME formulary

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

Our formulary guidelines allow you to obtain nonformulary DME items (those not listed on our DME 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.

Note: The following items are not covered under this "Durable Medical Equipment for Home Use" section:
• Diabetes urine-testing supplies and insulin-administration devices other than insulin pumps (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section)
• DME related to the terminal illness for Members who are receiving covered hospice care (instead, refer to "Hospice Care" in this "Benefits and Cost Sharing" section)

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

Health Education

We cover a variety of healthy living (health education) programs to help you take an active role in protecting and improving your health, including programs for tobacco-cessation, stress management, and chronic conditions (such as diabetes and asthma). We cover individual office visits at a $20 Copayment per visit (not subject to the Deductible). We provide all other covered Services at no charge (not subject to the Deductible). You can also participate in programs that we don't cover, which may require that you pay a fee.

For more information about our healthy living programs, please contact your local Health Education Department or call our Member Service Call Center, or go to our Web site at kp.org. Your Guidebook also includes information about our healthy living programs.

Home Health Care

Home health care means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover home health care at no charge (not subject to the Deductible) only if all of the following are true:
• You are substantially confined to your home (or a friend's or relative's home)
• Your condition requires the Services of a nurse, physical therapist, or speech therapist (home health aide Services are not covered unless you are also getting covered home health care from a nurse, physical therapist, or speech therapist that only a licensed provider can provide)
• A Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home
• The Services are provided inside our Service Area

We cover only part-time or intermittent home health care, as follows:
• Up to two hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to four hours per visit for visits by a home health aide
• Up to three visits per day (counting all home health visits)
Up to 100 visits per calendar year (counting all home health visits)

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

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

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

**Home health care exclusions**

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

**Hospice Care**

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

We cover the hospice Services listed below at **no charge (not subject to the Deductible)** only if all of the following requirements are met:

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

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

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from Plan Pharmacies. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call our Member Service Call Center for the current list of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling
- The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms:
Mental Health Services

We cover mental health Services as specified below, except that any outpatient visit limits specified in this "Mental Health Services" section under "Outpatient mental health Services" and inpatient day limits specified in this "Mental Health Services" section under "Inpatient psychiatric care" do not apply to the following conditions:

- These severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa
- A Serious Emotional Disturbance (SED) of a child under age 18, which means mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:
  - as a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either (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 all other mental health conditions, we cover evaluation, crisis intervention, and treatment only when a Plan Physician or when a Plan Provider who is a mental health professional believes the condition will significantly improve with relatively short-term therapy.

Outpatient mental health Services

We cover:

- Up to a total of 20 individual and group visits per calendar year for diagnostic evaluation and psychiatric treatment. Members who have exhausted the 20 visit limitation and who meet Medical Group criteria may receive up to 20 additional group visits in the same calendar year
- Psychological testing
- Visits for the purpose of monitoring drug therapy

You pay the following for these covered Services:

- Individual visits: a $20 Copayment per visit (not subject to the Deductible)
- Group visits: a $10 Copayment per visit (not subject to the Deductible)

Inpatient psychiatric care

We cover up to 30 days of psychiatric care in a Plan Hospital each calendar year. Coverage includes room and board, drugs, Services of Plan Physicians, and Services of other Plan Providers who are mental health professionals. We cover these Services at a $100 Copayment per day subject to the Deductible. The number of days of inpatient psychiatric care that we will cover during a calendar year is reduced by the amount of any hospital alternative Services we cover during the calendar year as described in the "Hospital alternative Services" section below.

Hospital alternative Services

We cover treatment in a structured multidisciplinary program as an alternative to inpatient psychiatric care at no charge subject to the Deductible. Each treatment period of hospital alternative Services we cover during a calendar year will reduce the number of days of inpatient psychiatric care that we will cover during that calendar year as follows:

- The inpatient psychiatric care benefit is reduced by one day for each two days of partial hospitalization
- The inpatient psychiatric care benefit is reduced by one day for each three days of treatment in an intensive outpatient psychiatric treatment program
- The inpatient psychiatric care benefit is reduced by one day for each hospital alternative treatment period of 24 hours
- The inpatient psychiatric care benefit is reduced by one day for every two hospital alternative treatment periods of 5 to 23 hours

Note: Outpatient drugs, supplies, and supplements are not covered under this "Mental Health Services" section
(instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section).

**Ostomy and Urological Supplies**

Inside our Service Area, we cover ostomy and urological supplies prescribed in accord with our soft goods formulary guidelines at 20% Coinsurance (not subject to the Deductible). We select the vendor, and coverage is limited to the standard supply that adequately meets your medical needs.

**About our soft goods formulary**

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

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

**Ostomy and urological supplies exclusion**

- Comfort, convenience, or luxury equipment or features

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

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

- Diagnostic and therapeutic imaging, such as X-rays, mammograms, and ultrasound: a $10 Copayment per encounter subject to the Deductible except that annual preventive mammograms are not subject to the Deductible and certain imaging procedures are covered at a $50 Copayment per procedure subject to the Deductible if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room; or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
  - Magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET): a $10 Copayment per procedure subject to the Deductible
  - Nuclear medicine: a $10 Copayment per encounter subject to the Deductible
  - Laboratory tests (including tests for specific genetic disorders for which genetic counseling is available): a $10 Copayment per encounter subject to the Deductible, except for the following:
    - Fecal occult blood tests are covered at no charge (not subject to the Deductible)
    - Laboratory tests to monitor the effectiveness of dialysis are covered at no charge subject to the Deductible
    - Cervical cancer screening including screening for HPV, prostate specific antigen, cholesterol test (lipid panel and profile), diabetes screening (fasting blood glucose test), STD tests, and HIV test are covered at a $10 Copayment per encounter (not subject to the Deductible) when they are ordered as a preventive screening test (and not to diagnose or treat an existing illness, injury, or condition that has already been diagnosed or for which you have symptoms)
  - Routine preventive retinal photography screenings: no charge (not subject to the Deductible)
  - All other diagnostic procedures provided by Plan Providers who are not physicians (such as electrocardiograms and electroencephalograms): a $10 Copayment per encounter subject to the Deductible except that certain diagnostic procedures are covered at a $50 Copayment per procedure subject to the Deductible if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room; or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
  - Radiation therapy: no charge subject to the Deductible
  - Ultraviolet light treatments: no charge subject to the Deductible
Outpatient Prescription Drugs, Supplies, and Supplements

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

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

How to obtain covered items

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

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

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

Outpatient drugs, supplies, and supplements

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

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

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

- Generic items (except for Single-Source Generic Drugs):
  - a $10 Copayment for up to a 30-day supply, a $20 Copayment for a 31- to 60-day supply, or a $30 Copayment for a 61- to 100-day supply
  - a $10 Copayment for up to a 30-day supply or a $20 Copayment for a 31- to 100-day supply through our mail order program
  - drugs prescribed for the treatment of sexual dysfunction disorders: 50% Coinsurance for up to a 100-day supply
- Brand name items, compounded products, and Single-Source Generic Drugs:
  - a $35 Copayment for up to a 30-day supply, a $70 Copayment for a 31- to 60-day supply, or a $105 Copayment for a 61- to 100-day supply
  - a $35 Copayment for up to a 30-day supply or a $70 Copayment for a 31- to 100-day supply through our mail order program
  - drugs prescribed for the treatment of sexual dysfunction disorders: 50% Coinsurance for up to a 100-day supply
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral
formula when used as a primary therapy for regional enteritis: no charge for up to a 30-day supply

- Emergency contraceptive pills: no charge
- Hematopoietic agents for dialysis: no charge for up to a 30-day supply
- Continuity drugs: If this Agreement is amended to exclude a drug that we have been covering and providing to you under this Agreement, 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 FDA at 50% Coinsurance for up to a 30-day supply in a 30-day period

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

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

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

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

Note: Diabetes blood-testing equipment (and their supplies) and insulin pumps (and their supplies) are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to "Durable Medical Equipment for Home Use" in this "Benefits and Cost Sharing" section).

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

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

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

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

Note: The following Services are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section:

- Durable medical equipment used to administer drugs (instead, refer to "Durable Medical Equipment for
Home Use" in this "Benefits and Cost Sharing" section)

- Outpatient administered drugs (instead, refer to "Outpatient Care" in this "Benefits and Cost Sharing" section)

- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (instead, refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care" in this "Benefits and Cost Sharing" section)

- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (instead, refer to "Hospice Care" in this "Benefits and Cost Sharing" section)

Outpatient prescription drugs, supplies, and supplements exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging

- Compounded products unless the drug is listed on our drug formulary or one of the ingredients requires a prescription by law

- Drugs when prescribed to shorten the duration of the common cold

Prosthetic and Orthotic Devices

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

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

Internally implanted devices

We cover at no charge subject to the Deductible internal devices implanted during covered surgery, such as pacemakers, cochlear implants, osseointegrated external hearing devices, and hip joints, that are approved by the federal Food and Drug Administration for general use.

External devices

We cover the following external prosthetic and orthotic devices, including repair and replacement of covered devices, at no charge (not subject to the Deductible):

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx

- 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 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

Prosthetic and orthotic devices exclusions

- Dental appliances

- Except as otherwise described above in this "Prosthetic and Orthotic Devices" section, nonrigid supplies, such as elastic stockings and wigs

- Comfort, convenience, or luxury equipment or features

- Electronic voice-producing machines

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

Reconstructive Surgery

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

You pay the following for covered reconstructive surgery Services:

- **Office visits:** a $20 Copayment per visit (not subject to the Deductible)
- **Outpatient surgery:** a $50 Copayment per procedure subject to the Deductible if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room; or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Any other outpatient surgery: a $20 Copayment per procedure (not subject to the Deductible)
- **Hospital inpatient care (including room and board, drugs, and Plan Physician Services): a $100 Copayment per day subject to the Deductible**

Note: The following Services are not covered under this "Reconstructive Surgery" section:

- Outpatient laboratory and imaging Services (instead, refer to "Outpatient Imaging, Laboratory, and Special Procedures" in this "Benefits and Cost Sharing" section)
- Outpatient prescription drugs (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section)
- Outpatient administered drugs (instead, refer to "Outpatient Care" in this "Benefits and Cost Sharing" section)
- Prosthetics and orthotics (instead, refer to "Prosthetic and Orthotic Devices" in this "Benefits and Cost Sharing" section)

Reconstructive surgery exclusions

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

Services Associated with Clinical Trials

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

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

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

Services associated with clinical trials exclusions

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

Skilled Nursing Facility Care

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

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

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our DME 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

Note: Outpatient imaging, laboratory, and special procedures are not covered under this "Skilled Nursing Facility Care" section (instead, refer to "Outpatient Imaging, Laboratory, and Special Procedures" in this "Benefits and Cost Sharing" section).

**Transplant Services**

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

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

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

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

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

Note: The following Services are not covered under this "Transplant Services" section:

- Outpatient laboratory and imaging Services (instead, refer to "Outpatient Imaging, Laboratory, and Special Procedures" in this "Benefits and Cost Sharing" section)
- Outpatient prescription drugs (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section)
- Outpatient administered drugs (instead, refer to "Outpatient Care" in this "Benefits and Cost Sharing" section)

**Exclusions, Limitations, and Reductions**

**Exclusions**

The Services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this Agreement. 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).
Certain exams and Services
Physical examinations and other Services (a) required for obtaining or maintaining employment or participation in employee programs, (b) required for insurance or licensing, or (c) on court order or required for parole or probation. This exclusion does not apply if a Plan Physician determines that the Services are Medically Necessary.

Chiropractic Services
Chiropractic Services and the Services of a chiropractor.

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

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

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

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

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

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 items when an investigational application has been filed with the federal Food and Drug Administration (FDA) and the manufacturer makes the item available to Kaiser Permanente
- Services covered under "Services Associated with Clinical Trials" in the "Benefits and Cost Sharing" section

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

Eye surgery, eyeglasses and contact lenses, and contact lens eye examinations

- Services related to eye surgery or orthokeratologic Services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism
- Eyeglass lenses and frames
- Contact lenses, including fitting and dispensing
- Eye examinations for the purpose of obtaining or maintaining contact lenses
- Low vision devices

This exclusion does not apply to contact lenses to treat aniridia or aphakia covered under "Outpatient Care" in the "Benefits and Cost Sharing" section.

Hair loss or growth treatment

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

Hearing aids

Hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid.
This exclusion does not apply to cochlear implants and osseointegrated external hearing devices covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section.

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 "Hospice Care" in the "Benefits and Cost Sharing" section.

Routine foot care Services
Routine foot care Services that are not Medically Necessary.

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

This exclusion does not apply to any of the following:
- Services covered under the "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non-Plan Providers" section that you receive outside the U.S.
- Experimental or investigational items when an investigational application has been filed with the FDA and the manufacturer makes the item available to Kaiser Permanente
- 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.

This exclusion is pending regulatory approval.

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

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

Surrogacy
Services for anyone in connection with a surrogacy arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Please refer to "Surrogacy arrangements" under "Reductions" in this "Exclusions, Limitations, and Reductions" section for information about your obligations to us in connection with a surrogacy arrangement, including your obligation to reimburse us for any Services we cover.

Transgender surgery

Travel and lodging expenses
Travel and lodging expenses, except that in some situations if the Medical Group refers you to a Non–Plan Provider as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines not subject to the Deductible. Our travel and lodging guidelines are available from our Member Service Call Center.

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

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

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

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

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

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

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

Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to:
  Kaiser Permanente
  Special Recovery Unit
  COB/TPL
  P.O. Box 2073
  Oakland, CA 94604-9877

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

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

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

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

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

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

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

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

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

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

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

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**U.S. Department of Veterans Affairs**

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

**Workers' compensation or employer's liability benefits**

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

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

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**Requests for Payment or Services**

**Requests for Payment**

**Emergency, Post-stabilization, or Out-of-Area Urgent Care**

If you receive Emergency Care, Post-stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider as described in the "Emergency, Post-stabilization, and Out-of-Area Urgent Care from Non–Plan Providers" section, you must pay for the Services unless the Non–Plan Provider agrees to bill us. If you want us to pay for the Services, you must file a claim. Also, if you receive Services from a Plan Provider that are prescribed by a Non–Plan Provider in conjunction with covered Emergency, Post-stabilization, and Out-of-Area Urgent Care, you may be required to pay for the Services and file a claim. We will reduce any payment we make to you or the Non–Plan Provider by the applicable Cost Sharing.

We will send you our written decision within 30 days after we receive the claim from you or the Non–Plan Provider unless we notify you, within that initial 30 days, that we need additional information from you or the Non–Plan Provider. We must receive the additional information within 45 days of our request in order for the
To request payment for Services that you believe should be covered, other than the Services described above, you must submit a written request to your local Member Services Department at a Plan Facility. Please attach any bills and receipts if you have paid any bills.

We will send you our written decision within 15 days of receiving the additional information. However, if we don't receive the additional information within 45 days of our request, we will send you our written decision no later than 90 days from the date of your initial request for payment.

If our decision is not fully in your favor, we will tell you the reasons and how to file a grievance.

How to file a claim. To file a claim, this is what you need to do:

- As soon as possible, request our claim form 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 send us our completed claim form for reimbursement. Please attach any bills and receipts from the Non–Plan Provider
- To request that a Non–Plan Provider be paid for Services, you must send us our completed claim form and include any bills from the Non–Plan Provider. If the Non–Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the Non–Plan Provider for covered Services other than your Cost Sharing amount, please call our Member Service Call Center toll free at 1-800-390-3510 for assistance
- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled. For example, we may require documents such as travel documents or original travel tickets to validate your claim
- The completed claim form must be mailed to the following address as soon as possible after receiving the care. Any additional information we request should also be mailed to this address:
  Kaiser Foundation Health Plan, Inc.
  Claims Department
  P.O. Box 12923
  Oakland, CA 94604-2923

Other Services
To request payment for Services that you believe should be covered, other than the Services described above, you must submit a written request to your local Member Services Department at a Plan Facility. Please attach any bills and receipts if you have paid any bills.

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

If we do not approve your request, we will tell you the reasons and how to file a grievance.

Requests for Services

Standard decision
If you have received a written denial of Services from the Medical Group or a “Notice of Non-Coverage” and you want to request that we cover the Services, you must file a grievance as described in the "Dispute Resolution" section within 180 days of the date you received the denial.

If you haven't received a written denial of Services, you may make a request for Services orally or in writing to your local Member Services Department at a Plan Facility. You will receive a written decision within 15 days unless you are notified that additional information is needed. The additional information must be received within 45 days of the request for information in order for it to be considered in the decision. You will receive a written decision within 15 days after we receive the additional information. If you don't supply the additional information within 45 days of the request, you will receive a written decision no later than 75 days after the date you made your request to Member Services. If we do not approve your request, we will send you a written decision that tells you the reasons and how to file a grievance.

If you believe we should cover a Medically Necessary Service that is not covered under this Agreement, you may file a grievance as described in the "Dispute Resolution" section.

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

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

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

• Call our Expedited Review Unit toll free at 1-888-987-7247 (TTY users call 1-800-777-1370), which is available Monday through Saturday from 8:30 a.m. to 5 p.m. After hours, you may leave a message and a representative will return your call the next business day.

• Send your written request to:
  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 23170
  Oakland, CA 94623-0170

• Fax your written request to our Expedited Review Unit toll free at 1-888-987-2252

• Deliver your request in person to your local Member Services Department at a Plan Facility

If we do not approve your request for an expedited decision, we will notify you and we will respond to your request for Services as described under "Standard decision." If we do not approve your request, we will send you a written decision that tells you the reasons and how to file a grievance.

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

Dispute Resolution

Grievances

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

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

• To a Member Services representative at your local Member Services Department at a Plan Facility (please refer to Your Guidebook for locations), or by calling our Member Service Call Center

• Through our Web site at kp.org

• To the following location for claims described under "Emergency, Post-stabilization, or Out-of-Area Urgent Care" under "Requests for Payment" in the "Requests for Payment or Services" section:
  Kaiser Permanente
  Special Services Unit
  P.O. Box 23280
  Oakland, CA 94623

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

Expedited grievance

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

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

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

• Call our Expedited Review Unit toll free at 1-888-987-7247 (TTY users call 1-800-777-1370), which is available Monday through Saturday from
8:30 a.m. to 5 p.m. After hours, you may leave a message and a representative will return your call the next business day

• Send your written request to:
  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 23170
  Oakland, CA 94623-0170

• Fax your written request to our Expedited Review Unit toll free at 1-888-987-2252

• Deliver your request in person to your local Member Services Department at a Plan Facility

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

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the DMHC directly at any time without first filing a grievance with us.

Supporting Documents

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

Who May File

The following persons may file a grievance:

• You may file for yourself

• You may appoint someone as your authorized representative by completing our authorization form. Authorization forms are available from your local Member Services Department at a Plan Facility or by calling our Member Service Call Center. Your completed authorization form must accompany the grievance

• You may file for your Dependent children, except that they must appoint you as their authorized representative if they have 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

• 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 health care proxy, to the extent provided under state law

• Your physician may request an expedited grievance as described under "Expedited grievance" in this "Dispute Resolution" section

DMHC Complaints

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

Independent Medical Review (IMR)

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

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

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

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

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

Experimental or investigational denials

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

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested. "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity

- If your treating physician is a Plan Physician, he or she recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying his or her recommendation

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

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

Binding Arbitration

For all claims subject to this "Binding Arbitration" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this Agreement. 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 Agreement or a Member Party's
relationship to Kaiser Foundation Health Plan, Inc. (Health Plan), including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, Services, irrespective of the legal theories upon which the claim is asserted

• The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
• The claim is not within the jurisdiction of the small claims court

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

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

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

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

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

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

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

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

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

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

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

**Payment of Arbitrators' Fees and Expenses**

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

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

**Costs**

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

**Rules of Procedure**

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

**General Provisions**

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondents served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (i) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (ii) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of 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 section.

**Termination of Membership**

Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2008, your last minute of coverage was at 11:59 p.m. on December 31, 2007). You will be billed as a non-Member for any Services you receive after your membership terminates. When your membership terminates, Health Plan and Plan Providers have no further liability or responsibility under this *Agreement*, except as provided under "Payments after Termination" in this "Termination of Membership" section.

**How You May Terminate Your Membership**

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

Kaiser Permanente
California Service Center
P.O. Box 23059
San Diego, CA 92193-3059
Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month. For example, if you become ineligible on December 5, 2007, your termination date is January 1, 2008, and your last minute of coverage is at 11:59 p.m. on December 31, 2007.

If your membership ends because you are no longer eligible to be a Dependent, but you continue to meet all other eligibility requirements, you will be able to enroll as a Subscriber without passing a new medical review if you request enrollment within 31 days after your membership termination date. However, you are not eligible if we terminate your membership under "Termination for Cause" in this "Termination of Membership" section. If we approve your application and you pay the required premiums, your coverage as a Subscriber will begin when your coverage under this Agreement ends. Your premiums may differ from those under this Agreement. For information about becoming a Subscriber, call our Member Service Call Center.

Termination for Cause

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

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

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

Termination for Nonpayment

Persons terminated for nonpayment may not enroll in Health Plan even after paying all amounts owed unless we approve the enrollment. Also, you must pass a medical review unless we reinstate your membership without a lapse in coverage.

Termination for nonpayment of Premiums

If we terminate this Agreement because we did not receive the required Premiums when due, then coverage for you and all your Dependents will end retroactively back to the last day of the month for which we received a full Premium payment. This retroactive period will not exceed 60 days before the date we mail you a notice confirming termination of membership. If we do not receive Premiums on or before the last day of the month preceding the month of coverage, we will send a Notice of Termination (notice of nonreceipt of payment) to the Subscriber's address of record. We will mail this notice at least 15 days before any termination of coverage and it will include the following information:

- A statement that we have not received full Premium payment and that we will terminate this Agreement for nonpayment if we do not receive the required Premiums within 15 days from the date the notice confirming termination of membership was mailed
- The specific date and time when coverage for you and all of your Dependents will end if we do not receive the Premiums

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

- That we have terminated this Agreement for nonpayment of Premiums
- The specific date and time when coverage for you and all your Dependents ended
- Information explaining whether or not you can reinstate this Agreement

Reinstatement of this Agreement after termination for nonpayment of Premiums. If we terminate this Agreement for nonpayment of Premiums, we will permit reinstatement of this Agreement twice during any 12-month period if we receive the amounts owed within 15 days of the date the notice confirming termination of membership was mailed to you. If you are reinstated, we will not require that you pass a medical review and Premiums will not change within the same calendar year (please note that Premiums change every January 1). We will not reinstate this Agreement if you do not obtain...
reinstatement of your terminated Agreement within the required 15 days, or if we terminate the Agreement for nonpayment of Premiums more than twice in a 12-month period. In either case, you will be ineligible to re-enroll for a period of 12 months from the effective date of termination and you will need to pass medical review.

**Termination for Discontinuance of a Product**

We may terminate your membership if we discontinue offering this product as permitted or required by law. If we continue to offer other individual (nongroup) products, we may terminate your membership under this product by sending you written notice at least 90 days before the termination date. You will be able to enroll in any other product we are then offering in the individual (nongroup) market if you meet all eligibility requirements (except for any medical review requirement). If we discontinue offering all individual (nongroup) products in California, or if we discontinue offering all individual (nongroup) products but continue to offer group products in the Service Area, the termination notice will include information about your right to enroll in an individual conversion plan. The premiums and coverage under the individual conversion plan may differ from those under this Agreement. To be eligible for the individual conversion plan, there must be no lapse in your coverage and we must receive your enrollment application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later). You may not convert to the individual conversion plan if either of the following is true:

- We terminated your membership under "Termination for Cause" in the "Termination of Membership" section
- You live in the service area of a Region outside California, except that the Subscriber's or the Subscriber's Spouse's otherwise-eligible children may be eligible to be covered Dependents even if they live in (or move to) the service area of a Region outside California (please refer to the "Who Is Eligible" section in the "Premiums, Eligibility, and Enrollment" section for more information)

**Payments after Termination**

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

- Within 30 days, refund any amounts we owe for Premiums you paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with "Requests for Payment" in the "Requests for Payment or Services" section

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

**State Review of Membership Termination**

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

**Rescission of Membership**

In order for us to accept you for enrollment, you must meet eligibility requirements and pass a medical review of the health information you provided in your enrollment application or during the enrollment process.

If we find an inconsistency between your current or past health on the date you were accepted for enrollment and the information provided in your enrollment application or during the enrollment process, we will notify you in writing why we believe we have grounds to rescind your membership (completely void your membership so that no coverage ever existed). Our notice will tell you why we believe your application may be inaccurate or incomplete and invite you to provide us with additional medical or other information to help us confirm that your actual medical status at the time you were accepted for enrollment qualified you for individual plan enrollment.

If after reviewing your reply we determine that you or someone on your behalf intentionally gave us incomplete or incorrect material information about your health, and our decision to accept your enrollment was based, in whole or in part, on the misinformation, we will rescind your coverage. We will explain the basis for our decision and how you can appeal. You will be required to pay as a non-Member for any Services we provided or covered under this Agreement. Within 30 days, we will refund all applicable Premiums except that we may subtract any amounts you owe us.
Miscellaneous Provisions

Administration of this Agreement
We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this Agreement.

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

• A Power of Attorney for Health Care lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your own views on life support and other treatments

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

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

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

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

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

Attorneys' 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 attorneys' fees and other expenses.

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

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 Agreement will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

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

Notices
Our notices to you will be sent to the most recent address we have for the Subscriber, except that notices related to amendment or renewal of this Agreement will be sent to the most recent e-mail address we have for the Subscriber if the Subscriber has opted to receive these agreements on our Web site at kp.org. The Subscriber is responsible for notifying us of any change in address. Subscribers who move (or change their e-mail address if the Subscriber has agreed to receive these agreements 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 Subscriber, he or she should contact our Member Service Call Center to discuss alternate delivery options.

Other formats for Members with disabilities
You can request a copy of this Agreement 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 (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number, or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

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

This is only a brief summary of some of our key privacy practices. Our Notice of Privacy Practices describing our policies and procedures for preserving the confidentiality of medical records and other PHI is available and will be furnished to you upon request. To request a copy, please call our Member Service Call Center. You can also find the notice at your local Plan Facility or on our Web site at kp.org.

Public policy participation
The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. A list of the Board of Directors is available on our Web site at kp.org 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 the 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.