

CONSIDERING A CHANGE?



THE CONVERSION DEDUCTIBLE 30/1500 PLAN
MIGHT BE RIGHT FOR YOU

GETTING STARTED

Please use this booklet along with the enclosed *Rate Chart Guide* to find the information you need to change from the Conversion Copayment 25 plan to the Conversion Deductible 30/1500 plan.

Because you were enrolled in your current Kaiser Permanente plan on the day the Affordable Care Act was passed, your coverage is grandfathered. That means that you will continue to enjoy similar benefits as before, although grandfathered coverage is not guaranteed indefinitely. Another advantage of grandfathered status is that you may be able to keep your plan after 2014, when the market will function very differently and health coverage choices may be limited.

To maintain your grandfathered coverage, you must remain within the same plan family. **That means you may change to the Conversion Deductible 30/1500 plan without losing your grandfathered status.**

However, if you drop your grandfathered Conversion coverage and apply to enroll in a Kaiser Permanente for Individuals and Families plan, you will need to go through medical review, and your new coverage will not be grandfathered. Also, since our 2012 plans that are open to new membership are structured as subscriber-only coverage, you'll lose your ability to enroll dependents in a family plan.

If you would like to change to the Conversion Deductible 30/1500 plan and maintain your grandfathered coverage, please follow these steps:

- Compare plans using the "Benefit Highlights" and "How Our Plan Types Work" sections in this book and the enclosed *Rate Chart Guide*.
- Review the *Membership Agreement* prior to enrollment.

To change plans, your current account must be paid up to the new plan's effective date.

Note:

Help in your language

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

Ayuda en su propio idioma

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

語言翻譯協助

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

BENEFIT HIGHLIGHTS

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

To assist you in evaluating a change to the Conversion Deductible 30/1500 plan, we've provided an overview of benefits and copayments for both the Copayment 25 and the Deductible 30/1500 plans. This overview is intended to help you compare coverage benefits and is a summary only. Please refer to the *Membership Agreement* for a detailed description of copayments and coinsurance for the Conversion Deductible 30/1500 plan.

	COPAYMENT 25	DEDUCTIBLE 30/1500
Features		
Individual plan annual deductible (subscriber only)	None	\$1,500
Family plan annual deductible (individual/family)	None	\$1,500/\$3,000
Individual plan annual out-of-pocket maximum (subscriber only)	\$2,500	\$3,500
Family plan annual out-of-pocket maximum (individual/family)	\$2,500/\$5,000	\$3,500/\$7,000
Benefits		
Preventive care (per visit)		
Immunizations	No charge	
Routine physical exam	\$25 copay	\$30 copay
Well-child visit (0–23 months)	No charge	\$30 copay
Well-woman visit	\$25 copay	\$30 copay
Mammogram	\$10 copay	
Outpatient services (per visit or procedure)		
Primary care/Specialty care office visit	\$25 copay	\$30 copay
Most X-rays and lab tests	\$10 copay	\$10 copay (after deductible)
MRI, CT, and PET	\$50 copay	\$50 copay (after deductible)
Outpatient surgery	\$100 copay	\$250 copay (after deductible)
Inpatient hospital care		
Room and board, surgery, anesthesia, X-rays, lab tests, and medications	\$200 copay per day	\$500 copay per day (after deductible)
Maternity		
Routine prenatal care visit	No charge	\$30 copay
Delivery and inpatient well-baby care	\$200 copay per day	\$500 copay per day (after deductible)
Emergency and urgent care		
Emergency Department visit (waived if admitted)	\$100 copay	\$150 copay (after deductible)
Urgent care visit	\$25 copay	\$30 copay
Ambulance service	\$100 copay	\$150 copay (after deductible)
Prescription drugs		
Plan pharmacy (up to a 30-day supply)	Generic: \$10 copay/Brand: \$35 copay	
Mail-order (up to a 100-day supply)	Generic: \$20 copay/Brand: \$70 copay	

For our deductible plan: Services listed above are not subject to the deductible unless otherwise indicated.

HOW OUR PLAN TYPES WORK

Copayment plans

With copayment plans, you pay set charges (or copayments) for certain covered services so you know your out-of-pocket expenses for doctor's visits, prescriptions, etc., in advance. And since you don't have to meet a deductible, you're eligible to pay copayments from the first day of coverage.

Deductible plans

Under a deductible plan, many covered services are subject to the deductible. That means you'll pay full charge for those services until you meet your annual deductible. After you reach your deductible, you will only pay a copayment or coinsurance for those covered services.

Some services are not subject to the deductible so you can pay a copay or coinsurance for these services from the first day of coverage. In fact, many preventive services are available for a copay from the first day of coverage.

Examples of how the two plan types work

Let's say you injure your ankle and visit your primary care physician who orders an X-ray. It's just a sprain, so the doctor prescribes a generic pain medication. Here's what you would pay under our two Conversion plans:

Copayment plan: On the Conversion Copayment 25 plan, you would pay a separate copayment (or copay) for each of the covered services you received. In this case, you would pay a \$25 copay for the doctor's office visit, a \$10 copay for the X-ray, and a \$10 copay for the generic drug. Your copays all contribute to your out-of-pocket maximum. No surprises. No deductible.

Deductible plan: On the Conversion Deductible 30/1500 plan, you have to pay \$1,500 out of pocket before you are eligible to pay a copay or coinsurance for most covered services. Copays and coinsurance do not apply toward your deductible; however, they do apply toward your out-of-pocket maximum.

In this example, if you have not met your deductible, you would pay a \$30 copay for the doctor's office visit and a \$10 copay for the generic drug because these services are not subject to the deductible under this plan. You would pay full charge for the X-ray, which would be applied to your \$1,500 annual deductible. After you meet your deductible, you would pay a \$10 copay for the X-ray.

COMMON TERMS

Annual out-of-pocket maximum: The maximum amount you'll pay for certain covered services in a calendar year. Once you've reached that maximum, you won't have to pay any deductibles, copays, or coinsurance for most covered services for the rest of the calendar year. Not all services apply toward the annual out-of-pocket maximum.

Coinsurance: The percentage of charges you pay when receiving certain covered services. For example, 30 percent coinsurance for hospitalization means you pay 30 percent of the charges for covered hospital services. Coinsurance, which varies depending on your plan, doesn't apply toward your deductible. But it does count toward your annual out-of-pocket maximum.

Copayment (or copay): The fixed fee you pay when you receive certain covered services or prescriptions. For example, a \$25 office visit copay means you pay \$25 for each office visit. Copayments, which vary depending on your plan, don't apply toward your deductible. But they do count toward your annual out-of-pocket maximum.

Deductible: A set amount you pay in a calendar year before we provide most covered services at a copay or coinsurance. Not all services may count toward the deductible.

HOW TO APPLY

1

Compare your plan choices using the “Benefits Highlights” section and the *Rate Chart Guide* included in this kit. If you change to the Conversion Deductible 30/1500 plan, you will not be able to switch back to the Conversion Copayment 25 plan after 30 days following your effective date.

2

Complete Section A of the plan change form on the next page. Complete all required fields to ensure we have your current information. Please remember to include your medical record number(s) in the area provided. Complete Section B of the plan change form. Indicate whether all or some of your family members are changing plans. Then complete the information for each family member who is changing plans. Sign and date the form as indicated and keep a copy for your records.

3

Please use the postage-paid envelope to mail your completed and signed plan change form to:

Kaiser Permanente
P.O. Box 23127
San Diego, CA 92193-3127

Or fax it to: **858-614-3345**

Once Kaiser Permanente has received and approved your request to change your plan, you will receive your first bill in the mail reflecting your new rate.

All payments are due by the first of each month.

Please consider your options carefully before failing to maintain or renew coverage for a child for whom you are responsible. If you attempt to obtain new individual coverage for that child, the premium for the same coverage may be higher than the premium you pay now.

Please print in ink only. Please see the instructions on the previous page *before* completing this form.

A. SUBSCRIBER INFORMATION (self or financially responsible party)

Last name	First name	MI	
	<input type="checkbox"/> M <input type="checkbox"/> F		
Medical record number	Gender		
Street address	City	State	ZIP
()	()		
Day phone: <input type="checkbox"/> Home <input type="checkbox"/> Work	Evening phone: <input type="checkbox"/> Home <input type="checkbox"/> Work		

B. FAMILY MEMBERS CHANGING PLANS (Please check one. Copy and attach more pages if needed.)

- All my family members are changing plans.
- Only the family members listed below are changing plans.

	Last name	First name	Medical record #
Applicant/Financially responsible party			
Applicant's spouse/ domestic partner			
Dependent (age 18 or over)			
Dependent (age 18 or over)			

Requested effective date: _____ (must be first of month). Effective dates are not guaranteed.

Kaiser Foundation Health Plan Arbitration Agreement:

I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation [29 CFR 2560.503-1], certain benefit-related disputes), any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Health Plan, its health care providers, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in Health Plan, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Membership Agreement*.

 X
Applicant/Financially responsible party _____ Today's date

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

 X
Dependent (age 18 or over) _____ Today's date

 X
Dependent (age 18 or over) _____ Today's date

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

KP.ORG

Rate chart guide

Kaiser Permanente for Individuals and Families ■ January 2012 ■ California

Please save this guide for future reference.

Your 2012 rate is based on your age—or the age of your younger spouse—as of January 1, 2012. (If you or your younger spouse turns 65 this year, you may find you can get a lower rate through Kaiser Permanente Senior Advantage. For more information, call **1-800-747-2189**.)

Your rate may increase or decrease if you:

- move to a new rate area
- add or drop a dependent
- change plans

If any of these changes apply to you, consult this *Rate Chart Guide* for your new rate. To use the *Rate Chart Guide*, first determine your rate area by finding your ZIP code in the lists on pages 2 and 3. Then locate the rate chart for your desired plan. Next, find your rate area in the top row and the subscriber's age as of January 1, 2012, in the left-hand column. Your rate will appear in the box where the subscriber's age and your family category intersect under that rate area.

Member Service Call Center representatives are available from 7 a.m. to 7 p.m., Monday through Friday, and 7 a.m. to 3 p.m., weekends, at **1-800-464-4000**.

Service area ZIP codes

Rate Area 1

94002	94139-47	94256-59	94585-92	94922-31	95044	95196	95462	95658-64	95840-43
94005	94151	94261-63	94595-99	94933	95046	95401-07	95465	95667-74	95851-53
94010-11	94156	94267-69	94601-15	94937-42	95050-56	95409	95471-73	95676-78	95860
94014-28	94158-64	94271	94617-24	94945-57	95070-71	95416	95476	95680-83	95864-67
94030	94172	94273-74	94649	94960	95076	95419	95486-87	95687-88	95894
94035	94177	94277	94659-62	94963-66	95101	95421	95492	95690-98	95899
94037-44	94188	94279-80	94666	94970-79	95103	95425	95602-05	95703	95903
94060-66	94203-09	94282-91	94701-10	94999	95106	95430-31	95607-21	95722	95961
94070	94211	94293-98	94712	95002	95108-13	95433	95623-26	95736	
94074	94229-30	94301-06	94720	95008-09	95115-36	95436	95628	95741-42	
94080	94232	94309	94801-08	95011	95138-41	95439	95630	95746-47	
94083	94234-37	94401-04	94820	95013-15	95148	95441-42	95632-35	95757-59	
94085-89	94239-40	94497	94850	95020-21	95150-61	95444	95638-40	95762-63	
94102-05	94244	94501-03	94901	95026	95164	95446	95645	95765	
94107-12	94246-50	94505-31	94903-04	95030-33	95170	95448	95648	95776	
94114-34	94252	94533-53	94912-15	95035-38	95172-73	95450	95650-52	95798-99	
94137	94254	94555-83	94920	95042	95190-94	95452	95655	95811-38	

Rate Area 2

90004-39	90311-12	91023-25	91214	91921	92049	92142-43	92623-30	92811-12	93015-16
90041-51	90401-11	91030-31	91221-22	91931-33	92051-52	92145	92637	92814-17	93022
90053-57	90620-24	91046	91224-26	91935	92054-61	92147	92646-63	92821-23	93030-36
90060	90630-33	91066	91501-08	91941-47	92064-65	92149-50	92672-79	92825	93040-44
90062-76	90637-39	91077	91510	91950-51	92067-69	92152-55	92683-85	92831-38	93060-61
90078-84	90680	91101-10	91521-23	91962-63	92071-72	92158-79	92688	92840-46	93066
90086-90	90720-21	91114-18	91709	91976-80	92074-75	92182	92690-94	92850	
90093-96	90740	91121	91754	91987	92078-79	92184	92697-98	92856-57	
90189	90742-43	91123-26	91756	92003	92081-86	92186-87	92701-08	92859	
90209-13	90895	91129	91775	92007-11	92088	92190-93	92711-12	92861	
90230-33	91001	91182	91780	92013-14	92091-93	92195-99	92728	92863-71	
90245	91003	91184-85	91801-04	92018-30	92096	92602-07	92735	92885-87	
90272	91006-12	91188-89	91896	92033	92101-24	92609-10	92780-82	92899	
90291-96	91016-17	91199	91901-03	92037-40	92126-32	92612	92799	93001-07	
90301-09	91020-21	91201-10	91908-17	92046	92134-40	92614-20	92801-09	93009-12	

Rate Area 3

90001-03	90247-51	90640	90801-10	91708	91761-73	92320-22	92369	92427	92581-87
90040	90254-55	90650-52	90813-15	91710-11	91776	92324-26	92371-78	92501-09	92589-93
90052	90260-62	90660-62	90822	91714-16	91778	92329	92382	92513-19	92595-96
90058-59	90266-67	90670-71	90831-35	91722-24	91784-86	92331	92385-86	92521-22	92599
90061	90270	90701-03	90840	91729-35	91788-93	92333-37	92391-95	92530-32	92860
90091	90274-75	90706-07	90842	91737	91795	92339-41	92397	92543-46	92877-83
90101	90277-78	90710-17	90844	91739-41	92220	92344-46	92399	92548	
90103	90280	90723	90846-48	91743-50	92223	92350	92401-08	92551-57	
90201-02	90310	90731-34	90853	91752	92305	92352	92410-15	92562-64	
90220-24	90501-10	90744-49	91701-02	91755	92307-08	92354	92418	92567	
90239-42	90601-10	90755	91706	91758-59	92313-18	92357-59	92423-24	92570-72	

Rate Area 4

90077	91324-31	91376-77	91426	93020-21	93222	93268	93383-90	93543-44	93599
90263-65	91333-35	91380-81	91436	93062-65	93224-26	93276	93501-02	93550-53	
90290	91337	91383-87	91470	93094	93238	93280	93504-05	93560-61	
91040-43	91340-46	91390	91482	93099	93240-41	93285	93510	93563	
91301-11	91350-62	91392-96	91495-96	93203	93243	93287	93518-19	93581	
91313	91364-65	91401-13	91499	93205-06	93249-52	93301-09	93531-32	93584	
91316	91367	91416	91601-12	93215-16	93261	93311-14	93534-36	93586	
91319-22	91371-72	91423	91614-18	93220	93263	93380	93539	93590-91	

Rate Area 5

92201-03	92230	92240-41	92252-56	92260-64	92270	92282			
92210-11	92234-36	92247-48	92258	92268	92274-78	92284-86			

Rate Area 6

93230	93611-14	93648-54	93701-12	93750	93844	95234	95296-97	95326	95376-78
93232	93616	93656-57	93714-18	93755	93888	95236-37	95304	95328-30	95380-82
93242	93618-19	93660	93720-30	93760-61	95201-13	95240-42	95307	95336-37	95385-87
93601-02	93623-27	93662	93737	93764-65	95215	95253	95313	95350-58	95391
93604	93630-31	93666-69	93741	93771-79	95219-20	95258	95316	95360-61	95397
93606-07	93636-39	93673	93744-45	93786	95227	95267	95319-20	95363	95641
93609	93643-46	93675	93747	93790-94	95230-31	95269	95323	95366-68	95686

Rate Area 7

Rate Area 7 applies to members who live outside Rate Areas 1-6.

Copayment 25 plan monthly rates

Age on January 1, 2012	Rate Area 1					Rate Area 2					Rate Area 3					Rate Area 4					Rate Area 5				
	Subscriber only	Subscriber + spouse	Subscriber + child	Subscriber + children	Subscriber, spouse, + child(ren)	Subscriber only	Subscriber + spouse	Subscriber + child	Subscriber + children	Subscriber, spouse, + child(ren)	Subscriber only	Subscriber + spouse	Subscriber + child	Subscriber + children	Subscriber, spouse, + child(ren)	Subscriber only	Subscriber + spouse	Subscriber + child	Subscriber + children	Subscriber, spouse, + child(ren)	Subscriber only	Subscriber + spouse	Subscriber + child	Subscriber + children	Subscriber, spouse, + child(ren)
19	\$459	\$931	\$904	\$1,504	\$1,599	\$399	\$816	\$788	\$1,314	\$1,407	\$421	\$858	\$831	\$1,382	\$1,482	\$442	\$902	\$872	\$1,453	\$1,555	\$464	\$945	\$914	\$1,523	\$1,632
20	479	979	928	1,524	1,672	419	867	816	1,339	1,485	442	911	858	1,411	1,565	464	957	901	1,482	1,642	486	1,003	945	1,552	1,722
21	499	1,030	953	1,547	1,751	440	918	844	1,368	1,569	464	965	889	1,438	1,652	487	1,013	933	1,511	1,732	510	1,062	977	1,582	1,815
22	520	1,081	979	1,569	1,832	462	974	873	1,394	1,655	486	1,023	918	1,467	1,744	511	1,074	963	1,541	1,829	533	1,123	1,009	1,615	1,917
23	533	1,105	994	1,584	1,883	474	992	885	1,411	1,696	498	1,045	931	1,484	1,786	523	1,096	977	1,557	1,875	547	1,149	1,023	1,633	1,965
24	545	1,130	1,008	1,601	1,938	484	1,013	895	1,426	1,739	508	1,065	941	1,501	1,830	537	1,120	989	1,575	1,921	561	1,174	1,038	1,652	2,012
25	559	1,157	1,020	1,620	1,992	496	1,033	907	1,441	1,781	521	1,089	955	1,519	1,876	547	1,144	1,003	1,594	1,968	572	1,198	1,050	1,669	2,062
26	571	1,183	1,035	1,637	2,050	506	1,055	919	1,458	1,825	532	1,111	967	1,535	1,922	561	1,169	1,014	1,613	2,017	586	1,224	1,064	1,689	2,114
27	584	1,208	1,047	1,655	2,109	518	1,077	931	1,475	1,871	544	1,135	980	1,552	1,970	572	1,193	1,028	1,632	2,068	598	1,249	1,077	1,708	2,165
28	598	1,232	1,060	1,671	2,153	530	1,099	943	1,490	1,912	559	1,157	991	1,569	2,012	586	1,217	1,042	1,647	2,113	613	1,273	1,091	1,727	2,213
29	610	1,256	1,074	1,689	2,201	544	1,122	955	1,507	1,951	571	1,179	1,004	1,587	2,055	601	1,241	1,054	1,666	2,159	629	1,298	1,106	1,745	2,262
30	625	1,280	1,086	1,708	2,247	555	1,144	967	1,523	1,994	586	1,203	1,018	1,603	2,101	615	1,266	1,069	1,683	2,206	646	1,326	1,120	1,764	2,312
31	639	1,305	1,101	1,727	2,296	569	1,166	979	1,538	2,038	601	1,227	1,030	1,620	2,145	630	1,290	1,082	1,701	2,254	659	1,351	1,133	1,785	2,361
32	652	1,332	1,115	1,745	2,347	584	1,188	991	1,555	2,082	615	1,251	1,043	1,637	2,191	646	1,315	1,096	1,720	2,301	676	1,378	1,149	1,803	2,412
33	664	1,354	1,123	1,757	2,371	593	1,207	999	1,565	2,099	625	1,271	1,050	1,645	2,210	656	1,336	1,101	1,728	2,320	685	1,399	1,156	1,812	2,431
34	674	1,377	1,132	1,773	2,395	601	1,225	1,004	1,572	2,116	634	1,290	1,055	1,655	2,227	664	1,356	1,110	1,739	2,339	697	1,421	1,162	1,820	2,449
35	686	1,400	1,142	1,786	2,420	610	1,246	1,009	1,579	2,133	642	1,310	1,064	1,664	2,245	676	1,377	1,116	1,747	2,357	707	1,443	1,171	1,830	2,470
36	697	1,422	1,149	1,798	2,446	620	1,264	1,014	1,589	2,148	652	1,331	1,069	1,674	2,262	685	1,399	1,122	1,756	2,376	719	1,463	1,176	1,839	2,488
37	710	1,446	1,159	1,812	2,470	630	1,285	1,023	1,596	2,165	663	1,353	1,076	1,683	2,279	697	1,421	1,130	1,766	2,395	729	1,487	1,183	1,849	2,509
38	717	1,465	1,164	1,815	2,476	639	1,302	1,030	1,601	2,176	673	1,371	1,084	1,688	2,289	705	1,439	1,139	1,773	2,403	741	1,507	1,193	1,856	2,517
39	727	1,482	1,171	1,817	2,482	649	1,322	1,040	1,609	2,182	683	1,390	1,093	1,694	2,298	717	1,460	1,149	1,778	2,412	751	1,530	1,203	1,863	2,527
40	736	1,497	1,176	1,820	2,485	659	1,339	1,047	1,615	2,191	695	1,411	1,101	1,700	2,306	727	1,482	1,157	1,785	2,422	763	1,550	1,213	1,870	2,538
41	744	1,514	1,183	1,822	2,490	669	1,358	1,055	1,620	2,199	705	1,429	1,111	1,706	2,315	739	1,502	1,166	1,791	2,431	776	1,572	1,222	1,876	2,548
42	754	1,533	1,188	1,827	2,493	680	1,378	1,065	1,625	2,208	717	1,450	1,120	1,711	2,323	751	1,523	1,176	1,796	2,441	787	1,594	1,232	1,883	2,556
43	770	1,564	1,207	1,836	2,509	691	1,399	1,074	1,630	2,213	727	1,472	1,132	1,717	2,330	763	1,545	1,186	1,800	2,446	800	1,618	1,244	1,887	2,563
44	785	1,598	1,224	1,844	2,522	702	1,419	1,086	1,633	2,220	739	1,492	1,142	1,720	2,335	776	1,569	1,200	1,805	2,451	812	1,642	1,258	1,892	2,570
45	802	1,628	1,241	1,854	2,534	714	1,439	1,094	1,637	2,225	751	1,514	1,154	1,723	2,340	788	1,592	1,210	1,810	2,459	827	1,667	1,268	1,895	2,575
46	821	1,664	1,261	1,863	2,550	724	1,462	1,106	1,640	2,230	763	1,538	1,164	1,727	2,346	802	1,615	1,222	1,813	2,465	839	1,691	1,281	1,900	2,582
47	838	1,698	1,280	1,873	2,563	736	1,482	1,116	1,643	2,235	776	1,560	1,176	1,730	2,352	814	1,638	1,232	1,817	2,470	853	1,718	1,292	1,904	2,587
48	860	1,737	1,302	1,885	2,580	756	1,519	1,135	1,659	2,250	793	1,598	1,196	1,745	2,368	834	1,679	1,254	1,832	2,488	875	1,759	1,314	1,921	2,606
49	882	1,779	1,324	1,900	2,597	773	1,555	1,154	1,672	2,269	814	1,638	1,215	1,761	2,385	855	1,720	1,275	1,847	2,505	897	1,800	1,336	1,936	2,626
50	906	1,822	1,346	1,914	2,616	792	1,592	1,174	1,686	2,286	834	1,677	1,235	1,774	2,403	875	1,761	1,297	1,863	2,524	919	1,844	1,358	1,951	2,645
51	929	1,866	1,368	1,927	2,635	812	1,632	1,195	1,701	2,301	855	1,718	1,258	1,790	2,422	897	1,803	1,319	1,878	2,541	941	1,890	1,382	1,968	2,663
52	953	1,914	1,392	1,943	2,652	833	1,672	1,215	1,713	2,318	877	1,761	1,276	1,805	2,439	919	1,847	1,341	1,895	2,561	965	1,936	1,404	1,987	2,684
53	979	1,965	1,422	1,980	2,680	853	1,711	1,239	1,742	2,337	899	1,803	1,303	1,832	2,459	943	1,892	1,370	1,924	2,582	989	1,982	1,434	2,016	2,706
54	1,008	2,016	1,451	2,017	2,708	875	1,752	1,263	1,768	2,356	921	1,844	1,329	1,861	2,480	965	1,936	1,397	1,953	2,602	1,013	2,029	1,462	2,048	2,728
55	1,035	2,072	1,484	2,057	2,738	895	1,795	1,288	1,795	2,374	943	1,890	1,356	1,892	2,497	989	1,983	1,424	1,983	2,623	1,038	2,079	1,490	2,079	2,750
56	1,064	2,126	1,514	2,097	2,767	918	1,837	1,314	1,822	2,393	965	1,936	1,383	1,919	2,517	1,014	2,031	1,453	2,014	2,645	1,064	2,128	1,521	2,111	2,772
57	1,094	2,184	1,547	2,138	2,796	940	1,881	1,339	1,853	2,412	989	1,982	1,412	1,949	2,538	1,042	2,079	1,482	2,046	2,665	1,089	2,181	1,552	2,143	2,794
58	1,115	2,228	1,565	2,167	2,822	960	1,926	1,356	1,876	2,432	1,009	2,026	1,428	1,975	2,560	1,062	2,126	1,501	2,074	2,687	1,111	2,230	1,572	2,172	2,816
59	1,135	2,272	1,584	2,199	2,844	979	1,970	1,373	1,902	2,453	1,031	2,072	1,446	2,004	2,580	1,084	2,176	1,519	2,101	2,709	1,133	2,279	1,591	2,203	2,840
60	1,135	2,272	1,584	2,199	2,844	979	1,970	1,373	1,902	2,453	1,031	2,072	1,446	2,004	2,580	1,084	2,176	1,519	2,101	2,709	1,133	2,279	1,591	2,203	2,840
61	1,135	2,272	1,584	2,199	2,844	979	1,970	1,373	1,902	2,453	1,031	2,072	1,446	2,004	2,580	1,084	2,176	1,519	2,101	2,709	1,133	2,279	1,591	2,203	2,840
62	1,135	2,272	1,584	2,199	2,844	979	1,970	1,373	1,902	2,453	1,031	2,072	1,446	2,004	2,580	1,084	2,176	1,519	2,101	2,709	1,133	2,279	1,591	2,203	2,840
63	1,135	2,272	1,584	2,199	2,844	979	1,970	1,373	1,902	2,453	1,031	2,072	1,446	2,004	2,580	1,084	2,176	1,519	2,101	2,709	1,133	2,279	1,591	2,203	2,840
64	1,135	2,272	1,584	2,199	2,844	979	1,970	1,373	1,902	2,453	1,031	2,072	1,446	2,004	2,580	1,084	2,176	1,519	2,101	2,709	1,133	2,279	1,591	2,203	2,840
65+	2,272	4,540	3,121	4,363	5,555	2,191	4,379	3,002	4,209	5,353	2,303	4,607	3,160	4,431	5,635	2,420	4,841	3,320	4,652	5,917	2,534	5,069	3,479	4,873	6,198

Copayment 25 plan monthly rates

Age on January 1, 2012	Rate Area 6					Rate Area 7				
	Subscriber only	Subscriber + spouse	Subscriber + child	Subscriber + children	Subscriber, spouse, + child(ren)	Subscriber only	Subscriber + spouse	Subscriber + child	Subscriber + children	Subscriber, spouse, + child(ren)
19	\$436	\$884	\$858	\$1,428	\$1,518	\$464	\$945	\$914	\$1,523	\$1,632
20	455	929	882	1,448	1,591	486	1,003	945	1,552	1,722
21	476	977	906	1,468	1,664	510	1,062	977	1,582	1,815
22	496	1,030	931	1,489	1,742	533	1,123	1,009	1,615	1,917
23	506	1,052	945	1,506	1,790	547	1,149	1,023	1,633	1,965
24	518	1,076	957	1,519	1,841	561	1,174	1,038	1,652	2,012
25	532	1,099	970	1,536	1,893	572	1,198	1,050	1,669	2,062
26	542	1,123	980	1,553	1,948	586	1,224	1,064	1,689	2,114
27	555	1,147	996	1,572	2,004	598	1,249	1,077	1,708	2,165
28	567	1,169	1,008	1,589	2,046	613	1,273	1,091	1,727	2,213
29	581	1,193	1,020	1,604	2,091	629	1,298	1,106	1,745	2,262
30	593	1,217	1,033	1,623	2,136	646	1,326	1,120	1,764	2,312
31	606	1,241	1,045	1,640	2,182	659	1,351	1,133	1,785	2,361
32	622	1,266	1,059	1,659	2,228	676	1,378	1,149	1,803	2,412
33	630	1,286	1,065	1,671	2,252	685	1,399	1,156	1,812	2,431
34	642	1,309	1,076	1,683	2,276	697	1,421	1,162	1,820	2,449
35	651	1,331	1,082	1,694	2,300	707	1,443	1,171	1,830	2,470
36	663	1,353	1,093	1,708	2,325	719	1,463	1,176	1,839	2,488
37	673	1,375	1,101	1,722	2,349	729	1,487	1,183	1,849	2,509
38	683	1,390	1,106	1,723	2,352	741	1,507	1,193	1,856	2,517
39	690	1,405	1,111	1,727	2,357	751	1,530	1,203	1,863	2,527
40	698	1,422	1,118	1,728	2,361	763	1,550	1,213	1,870	2,538
41	708	1,439	1,123	1,732	2,364	776	1,572	1,222	1,876	2,548
42	715	1,455	1,128	1,734	2,371	787	1,594	1,232	1,883	2,556
43	732	1,485	1,145	1,744	2,381	800	1,618	1,244	1,887	2,563
44	748	1,516	1,162	1,752	2,395	812	1,642	1,258	1,892	2,570
45	763	1,548	1,181	1,759	2,407	827	1,667	1,268	1,895	2,575
46	778	1,581	1,196	1,769	2,420	839	1,691	1,281	1,900	2,582
47	795	1,615	1,215	1,778	2,434	853	1,718	1,292	1,904	2,587
48	817	1,652	1,235	1,791	2,449	875	1,759	1,314	1,921	2,606
49	838	1,691	1,258	1,803	2,466	897	1,800	1,336	1,936	2,626
50	860	1,732	1,278	1,817	2,485	919	1,844	1,358	1,951	2,645
51	882	1,774	1,300	1,832	2,502	941	1,890	1,382	1,968	2,663
52	906	1,817	1,322	1,844	2,519	965	1,936	1,404	1,987	2,684
53	929	1,864	1,349	1,880	2,546	989	1,982	1,434	2,016	2,706
54	955	1,915	1,380	1,917	2,573	1,013	2,029	1,462	2,048	2,728
55	984	1,966	1,409	1,953	2,601	1,038	2,079	1,490	2,079	2,750
56	1,011	2,019	1,439	1,992	2,629	1,064	2,128	1,521	2,111	2,772
57	1,038	2,075	1,468	2,031	2,658	1,089	2,181	1,552	2,143	2,794
58	1,057	2,116	1,487	2,058	2,679	1,111	2,230	1,572	2,172	2,816
59	1,077	2,159	1,506	2,089	2,701	1,133	2,279	1,591	2,203	2,840
60	1,077	2,159	1,506	2,089	2,701	1,133	2,279	1,591	2,203	2,840
61	1,077	2,159	1,506	2,089	2,701	1,133	2,279	1,591	2,203	2,840
62	1,077	2,159	1,506	2,089	2,701	1,133	2,279	1,591	2,203	2,840
63	1,077	2,159	1,506	2,089	2,701	1,133	2,279	1,591	2,203	2,840
64	1,077	2,159	1,506	2,089	2,701	1,133	2,279	1,591	2,203	2,840
65+	2,160	4,311	2,964	4,148	5,278	2,534	5,069	3,479	4,873	6,198

Child-only rates

Age on January 1, 2012

	Rate Area 1	Rate Area 2	Rate Area 3	Rate Area 4	Rate Area 5	Rate Area 6	Rate Area 7
One child age <1	\$423	\$363	\$384	\$401	\$421	\$401	\$421
One child ages 1-18	423	363	384	401	421	401	421
Two children	844	725	766	804	844	800	844
Three+ children	1,462	1,264	1,329	1,397	1,463	1,387	1,463

Deductible 30/1500 plan monthly rates

Age on January 1, 2012	Rate Area 1					Rate Area 2					Rate Area 3					Rate Area 4					Rate Area 5				
	Subscriber only	Subscriber + spouse	Subscriber + child	Subscriber + children	Subscriber, spouse, + child(ren)	Subscriber only	Subscriber + spouse	Subscriber + child	Subscriber + children	Subscriber, spouse, + child(ren)	Subscriber only	Subscriber + spouse	Subscriber + child	Subscriber + children	Subscriber, spouse, + child(ren)	Subscriber only	Subscriber + spouse	Subscriber + child	Subscriber + children	Subscriber, spouse, + child(ren)	Subscriber only	Subscriber + spouse	Subscriber + child	Subscriber + children	Subscriber, spouse, + child(ren)
19	\$273	\$552	\$549	\$860	\$899	\$234	\$476	\$470	\$712	\$756	\$248	\$499	\$496	\$749	\$795	\$260	\$525	\$520	\$787	\$836	\$272	\$550	\$547	\$824	\$875
20	282	574	564	884	948	243	494	484	729	800	256	520	510	768	841	270	545	535	807	884	282	572	561	844	924
21	292	600	581	911	997	253	513	498	748	844	265	540	525	787	887	278	567	550	826	931	292	595	576	865	977
22	304	623	596	936	1,050	260	533	511	765	890	275	564	538	805	938	289	589	566	846	986	302	618	593	887	1,030
23	312	642	605	938	1,067	270	550	520	773	907	283	579	549	816	953	299	608	576	858	1,003	314	637	603	899	1,050
24	324	663	612	940	1,082	280	569	530	785	924	294	598	557	826	972	311	627	586	867	1,021	326	657	613	909	1,069
25	334	685	622	943	1,101	290	586	538	793	941	304	617	567	836	991	321	647	596	878	1,040	336	678	625	921	1,089
26	346	705	629	945	1,118	300	605	549	804	958	316	635	578	846	1,009	333	668	608	889	1,060	348	698	635	931	1,110
27	357	727	639	948	1,137	312	623	559	814	977	328	656	589	858	1,028	343	688	617	901	1,079	360	720	647	943	1,130
28	370	756	656	975	1,183	321	646	571	829	1,008	336	678	600	873	1,062	355	712	630	919	1,115	372	746	661	962	1,167
29	384	783	674	1,003	1,230	331	668	583	846	1,040	348	703	613	890	1,096	367	736	644	935	1,149	382	771	674	982	1,205
30	397	814	691	1,033	1,281	340	690	595	865	1,072	357	727	625	909	1,130	375	763	656	953	1,186	394	800	688	1,001	1,244
31	411	843	714	1,062	1,332	351	714	606	882	1,108	368	751	637	928	1,167	389	790	669	974	1,224	406	827	703	1,021	1,283
32	426	875	731	1,093	1,387	360	737	618	899	1,144	379	776	651	946	1,205	399	819	685	992	1,263	418	858	715	1,042	1,324
33	435	890	742	1,098	1,394	370	759	630	912	1,171	389	797	664	960	1,234	409	839	695	1,008	1,295	428	878	729	1,057	1,356
34	445	904	754	1,106	1,402	379	776	642	926	1,200	399	819	674	974	1,264	418	861	708	1,025	1,326	438	902	742	1,072	1,388
35	453	919	763	1,111	1,411	389	797	652	941	1,229	409	841	686	989	1,295	430	884	722	1,040	1,358	450	924	756	1,089	1,422
36	465	936	775	1,118	1,419	397	819	664	957	1,259	418	861	698	1,004	1,326	440	906	734	1,057	1,392	460	948	770	1,106	1,456
37	474	952	785	1,125	1,428	409	841	674	970	1,288	430	884	710	1,021	1,358	452	929	748	1,071	1,424	472	972	783	1,123	1,492
38	489	984	805	1,154	1,484	419	861	693	991	1,320	442	907	731	1,043	1,392	465	952	766	1,096	1,460	487	997	804	1,147	1,530
39	504	1,018	826	1,186	1,541	433	884	712	1,011	1,354	455	929	749	1,065	1,426	477	979	787	1,118	1,497	501	1,023	826	1,171	1,569
40	521	1,054	846	1,217	1,603	447	906	731	1,033	1,387	469	953	768	1,088	1,462	493	1,003	807	1,142	1,535	516	1,048	846	1,198	1,608
41	538	1,091	870	1,251	1,666	459	929	749	1,057	1,422	484	980	788	1,111	1,499	508	1,028	829	1,167	1,574	532	1,077	868	1,222	1,649
42	554	1,128	892	1,285	1,732	472	953	770	1,079	1,458	498	1,006	809	1,137	1,536	523	1,055	850	1,191	1,615	549	1,105	890	1,247	1,689
43	572	1,166	916	1,302	1,756	489	984	790	1,101	1,490	515	1,038	831	1,159	1,570	540	1,088	872	1,218	1,649	567	1,140	912	1,276	1,727
44	593	1,203	938	1,319	1,779	506	1,016	809	1,125	1,523	532	1,069	851	1,184	1,603	559	1,123	894	1,244	1,683	586	1,176	938	1,302	1,762
45	613	1,242	963	1,334	1,802	525	1,047	829	1,147	1,557	550	1,103	873	1,208	1,638	578	1,159	918	1,269	1,720	606	1,215	962	1,329	1,802
46	635	1,281	989	1,351	1,827	540	1,081	851	1,171	1,591	571	1,139	895	1,235	1,676	598	1,195	941	1,297	1,757	627	1,252	986	1,358	1,841
47	657	1,324	1,014	1,370	1,853	559	1,115	872	1,198	1,625	589	1,176	919	1,261	1,711	618	1,234	965	1,324	1,796	649	1,293	1,009	1,387	1,881
48	676	1,360	1,035	1,402	1,900	578	1,149	890	1,222	1,660	610	1,210	938	1,285	1,751	639	1,269	984	1,351	1,836	669	1,332	1,030	1,414	1,924
49	695	1,399	1,055	1,436	1,953	596	1,184	909	1,244	1,698	629	1,247	957	1,312	1,788	661	1,309	1,004	1,377	1,875	691	1,373	1,052	1,441	1,966
50	715	1,438	1,076	1,468	2,006	617	1,220	928	1,269	1,734	649	1,285	977	1,336	1,827	681	1,351	1,025	1,402	1,915	714	1,416	1,072	1,472	2,009
51	737	1,477	1,098	1,502	2,058	635	1,258	946	1,295	1,773	669	1,324	997	1,363	1,866	703	1,392	1,047	1,431	1,958	736	1,458	1,096	1,499	2,053
52	758	1,518	1,120	1,538	2,114	657	1,297	965	1,320	1,810	691	1,365	1,016	1,388	1,907	725	1,434	1,067	1,458	2,002	761	1,502	1,120	1,530	2,097
53	776	1,555	1,137	1,564	2,131	671	1,327	980	1,344	1,829	707	1,399	1,031	1,416	1,927	742	1,470	1,084	1,485	2,023	776	1,540	1,137	1,558	2,118
54	793	1,589	1,154	1,589	2,148	686	1,361	997	1,371	1,847	722	1,433	1,048	1,443	1,946	756	1,506	1,101	1,516	2,043	793	1,577	1,156	1,589	2,142
55	812	1,628	1,171	1,616	2,165	702	1,395	1,011	1,399	1,868	736	1,470	1,064	1,472	1,966	773	1,543	1,120	1,545	2,063	810	1,616	1,171	1,618	2,164
56	831	1,666	1,188	1,643	2,181	715	1,431	1,026	1,424	1,887	751	1,504	1,081	1,501	1,985	790	1,581	1,137	1,575	2,085	827	1,657	1,190	1,650	2,184
57	851	1,706	1,205	1,671	2,198	731	1,465	1,043	1,453	1,905	768	1,541	1,098	1,530	2,006	807	1,620	1,156	1,604	2,106	846	1,696	1,208	1,681	2,206
58	867	1,742	1,225	1,700	2,225	746	1,499	1,060	1,477	1,929	785	1,577	1,116	1,557	2,031	824	1,657	1,174	1,633	2,131	865	1,735	1,227	1,710	2,233
59	885	1,779	1,244	1,732	2,250	763	1,533	1,077	1,502	1,953	802	1,613	1,135	1,582	2,055	841	1,694	1,191	1,660	2,160	882	1,774	1,247	1,739	2,262
60	885	1,779	1,244	1,732	2,250	763	1,533	1,077	1,502	1,953	802	1,613	1,135	1,582	2,055	841	1,694	1,191	1,660	2,160	882	1,774	1,247	1,739	2,262
61	885	1,779	1,244	1,732	2,250	763	1,533	1,077	1,502	1,953	802	1,613	1,135	1,582	2,055	841	1,694	1,191	1,660	2,160	882	1,774	1,247	1,739	2,262
62	885	1,779	1,244	1,732	2,250	763	1,533	1,077	1,502	1,953	802	1,613	1,135	1,582	2,055	841	1,694	1,191	1,660	2,160	882	1,774	1,247	1,739	2,262
63	885	1,779	1,244	1,732	2,250	763	1,533	1,077	1,502	1,953	802	1,613	1,135	1,582	2,055	841	1,694	1,191	1,660	2,160	882	1,774	1,247	1,739	2,262
64	885	1,779	1,244	1,732	2,250	763	1,533	1,077	1,502	1,953	802	1,613	1,135	1,582	2,055	841	1,694	1,191	1,660	2,160	882	1,774	1,247	1,739	2,262
65+	2,272	4,540	3,121	4,363	5,555	2,191	4,379	3,002	4,209	5,353	2,303	4,607	3,160	4,431	5,635	2,420	4,841	3,320	4,652	5,917	2,534	5,069	3,479	4,873	6,198

Deductible 30/1500 plan monthly rates

Age on January 1, 2012	Rate Area 6					Rate Area 7				
	Subscriber only	Subscriber + spouse	Subscriber + child	Subscriber + children	Subscriber, spouse, + child(ren)	Subscriber only	Subscriber + spouse	Subscriber + child	Subscriber + children	Subscriber, spouse, + child(ren)
19	\$260	\$525	\$521	\$817	\$856	\$272	\$550	\$547	\$824	\$875
20	268	545	535	841	901	282	572	561	844	924
21	277	567	550	865	950	292	595	576	865	977
22	287	589	566	890	999	302	618	593	887	1,030
23	295	608	574	892	1,014	314	637	603	899	1,050
24	307	629	583	894	1,031	326	657	613	909	1,069
25	316	649	589	897	1,048	336	678	625	921	1,089
26	328	669	600	899	1,065	348	698	635	931	1,110
27	338	691	606	901	1,081	360	720	647	943	1,130
28	351	719	623	926	1,125	372	746	661	962	1,167
29	365	744	642	953	1,169	382	771	674	982	1,205
30	377	773	659	980	1,217	394	800	688	1,001	1,244
31	391	802	678	1,009	1,266	406	827	703	1,021	1,283
32	406	833	697	1,038	1,315	418	858	715	1,042	1,324
33	414	844	705	1,043	1,324	428	878	729	1,057	1,356
34	423	860	715	1,050	1,331	438	902	742	1,072	1,388
35	431	875	725	1,055	1,339	450	924	756	1,089	1,422
36	442	890	736	1,062	1,348	460	948	770	1,106	1,456
37	452	904	744	1,069	1,354	472	972	783	1,123	1,492
38	465	936	765	1,098	1,409	487	997	804	1,147	1,530
39	481	969	783	1,127	1,465	501	1,023	826	1,171	1,569
40	494	1,001	804	1,157	1,523	516	1,048	846	1,198	1,608
41	511	1,035	824	1,188	1,582	532	1,077	868	1,222	1,649
42	527	1,072	846	1,222	1,645	549	1,105	890	1,247	1,689
43	545	1,106	870	1,235	1,667	567	1,140	912	1,276	1,727
44	564	1,144	892	1,251	1,691	586	1,176	938	1,302	1,762
45	583	1,179	916	1,268	1,713	606	1,215	962	1,329	1,802
46	603	1,217	938	1,285	1,735	627	1,252	986	1,358	1,841
47	623	1,258	963	1,302	1,759	649	1,293	1,009	1,387	1,881
48	642	1,293	982	1,331	1,805	669	1,332	1,030	1,414	1,924
49	661	1,329	1,003	1,363	1,854	691	1,373	1,052	1,441	1,966
50	680	1,366	1,023	1,394	1,905	714	1,416	1,072	1,472	2,009
51	700	1,404	1,043	1,426	1,955	736	1,458	1,096	1,499	2,053
52	719	1,443	1,065	1,460	2,009	761	1,502	1,120	1,530	2,097
53	736	1,477	1,079	1,485	2,024	776	1,540	1,137	1,558	2,118
54	754	1,511	1,094	1,509	2,041	793	1,577	1,156	1,589	2,142
55	770	1,547	1,111	1,536	2,055	810	1,616	1,171	1,618	2,164
56	788	1,584	1,127	1,562	2,072	827	1,657	1,190	1,650	2,184
57	807	1,621	1,144	1,587	2,089	846	1,696	1,208	1,681	2,206
58	824	1,657	1,162	1,616	2,113	865	1,735	1,227	1,710	2,233
59	841	1,691	1,179	1,645	2,140	882	1,774	1,247	1,739	2,262
60	841	1,691	1,179	1,645	2,140	882	1,774	1,247	1,739	2,262
61	841	1,691	1,179	1,645	2,140	882	1,774	1,247	1,739	2,262
62	841	1,691	1,179	1,645	2,140	882	1,774	1,247	1,739	2,262
63	841	1,691	1,179	1,645	2,140	882	1,774	1,247	1,739	2,262
64	841	1,691	1,179	1,645	2,140	882	1,774	1,247	1,739	2,262
65+	2,160	4,311	2,964	4,148	5,278	2,534	5,069	3,479	4,873	6,198

Child-only rates

Age on January 1, 2012

	Rate Area 1	Rate Area 2	Rate Area 3	Rate Area 4	Rate Area 5	Rate Area 6	Rate Area 7
One child age <1	\$255	\$219	\$231	\$243	\$255	\$243	\$255
One child ages 1-18	255	219	231	243	255	243	255
Two children	510	438	460	487	510	487	510
Three+ children	812	678	714	749	785	773	785



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

A nonprofit corporation

2012 Individual Plan Membership Agreement and Disclosure Form and Evidence of Coverage for Kaiser Permanente Individual—Conversion Plan

Deductible 30/1500 Plan

Highlights

Deductible for certain Services \$1,500 per calendar year for one Member and \$3,000 for a Family

Copayments and Coinsurance after Deductible is met:

Most consultations, exams, and treatment.....	\$30 per visit (Deductible doesn't apply)
Hospital inpatient care.....	\$500 per day after Deductible
Outpatient surgery.....	\$250 per procedure after Deductible
Emergency Department visits.....	\$150 per visit after Deductible
Most generic drugs.....	\$10 for up to a 30-day supply (Deductible doesn't apply)
Most brand-name drugs.....	\$35 for up to a 30-day supply (Deductible doesn't apply)

Pending regulatory approval

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

Help in your language

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

Ayuda en su propio idioma

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

語言翻譯協助

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

TABLE OF CONTENTS

Health Plan Benefits and Coverage Matrix	1
Introduction	3
Term of this <i>Membership Agreement and Evidence of Coverage, Renewal, and Amendment</i>	3
About Kaiser Permanente	4
Definitions	4
Premiums, Eligibility, and Enrollment	9
Premiums	9
Who Is Eligible	10
How to Enroll	12
How to Obtain Services	12
Routine Care	12
Urgent Care	13
Not Sure What Kind of Care You Need?	13
Your Personal Plan Physician	13
Getting a Referral	13
Second Opinions	15
Contracts with Plan Providers	15
Visiting Other Regions	16
Your ID Card	16
Getting Assistance	16
Plan Facilities	17
Plan Hospitals and Plan Medical Offices	17
<i>Your Guidebook to Kaiser Permanente Services (Your Guidebook)</i>	21
Emergency Services and Urgent Care	21
Emergency Services	21
Urgent Care	22
Payment and Reimbursement	23
Benefits and Cost Sharing	24
Cost Sharing	25
Preventive Care Services	27
Outpatient Care	28
Hospital Inpatient Care	29
Ambulance Services	30
Bariatric Surgery	30
Chemical Dependency Services	31
Dental and Orthodontic Services	31
Dialysis Care	32
Durable Medical Equipment for Home Use	33
Health Education	34
Hearing Services	35
Home Health Care	35
Hospice Care	36
Mental Health Services	36
Ostomy and Urological Supplies	38
Outpatient Imaging, Laboratory, and Special Procedures	38
Outpatient Prescription Drugs, Supplies, and Supplements	39
Prosthetic and Orthotic Devices	41
Reconstructive Surgery	42
Services Associated with Clinical Trials	42

Skilled Nursing Facility Care	43
Transplant Services	43
Vision Services.....	44
Exclusions, Limitations, Coordination of Benefits, and Reductions	45
Exclusions	45
Limitations	47
Coordination of Benefits	47
Reductions.....	47
Dispute Resolution	49
Grievances.....	49
Supporting Documents	51
Who May File.....	51
Department of Managed Health Care Complaints.....	51
Independent Medical Review (IMR).....	51
Binding Arbitration	52
Termination of Membership.....	55
How You May Terminate Your Membership	55
Termination Due to Loss of Eligibility	55
Termination for Cause.....	55
Termination for Nonpayment of Premiums.....	55
Termination for Discontinuance of a Product	56
Payments after Termination	56
State Review of Membership Termination.....	56
Miscellaneous Provisions	57
Helpful Information.....	58
Your Guidebook to Kaiser Permanente Services (Your Guidebook).....	58
How to Reach Us.....	59
Payment Responsibility.....	60
Chiropractic Services Amendment.....	60
Definitions.....	60
Participating Providers	61
Covered Services.....	61
Exclusions and Limitations	63
Member Services.....	63
Grievances.....	63

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.

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Call Center.

Annual Out-of-Pocket Maximum for Certain Services

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

For self-only enrollment (a Family of one Member).....	\$3,500 per calendar year
For any one Member in a Family of two or more Members	\$3,500 per calendar year
For an entire Family of two or more Members	\$7,000 per calendar year

Deductible for Certain Services

For Services subject to the Deductible, 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 of one Member).....	\$1,500 per calendar year
For any one Member in a Family of two or more Members	\$1,500 per calendar year
For an entire Family of two or more Members	\$3,000 per calendar year

Lifetime Maximum

None

Professional Services (Plan Provider office visits)

You Pay

Most primary and specialty care consultations, exams, and treatment.....	\$30 per visit (Deductible doesn't apply)
Routine physical maintenance exams.....	\$30 per visit (Deductible doesn't apply)
Well-child preventive exams (through age 23 months).....	\$30 per visit (Deductible doesn't apply)
Family planning counseling	\$30 per visit (Deductible doesn't apply)
Scheduled prenatal care exams and first postpartum follow-up consultation and exam.....	\$30 per visit (Deductible doesn't apply)
Eye exams for refraction	\$30 per visit (Deductible doesn't apply)
Hearing exams.....	\$30 per visit (Deductible doesn't apply)
Urgent care consultations, exams, and treatment	\$30 per visit (Deductible doesn't apply)
Chiropractic office visits	\$15 per visit (Deductible doesn't apply)
Physical, occupational, and speech therapy	\$30 per visit after Deductible

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures.....	\$250 per procedure after Deductible
Allergy injections (including allergy serum).....	\$5 per visit after Deductible
Most immunizations (including the vaccine).....	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests.....	\$10 per encounter after Deductible
Preventive X-rays, screenings, and laboratory tests as described in the "Benefits and Cost Sharing" section.....	\$10 per encounter (Deductible doesn't apply)
MRI, CT, and PET scans.....	\$50 per procedure after Deductible
Health education:	
Most individual health education counseling.....	\$30 per visit (Deductible doesn't apply)
Covered health education programs.....	No charge (Deductible doesn't apply)

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.	\$500 per day after Deductible
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Emergency Health Coverage

You Pay

Emergency Department visits	\$150 per visit after Deductible
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Note: After you meet the Deductible, this Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).

Ambulance Services	You Pay
Ambulance Services.....	\$150 per trip after Deductible
Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	\$10 for up to a 30-day supply, \$20 for a 31- to 60-day supply, or \$30 for a 61- to 100-day supply (Deductible doesn't apply)
Most generic refills through our mail-order service.....	\$10 for up to a 30-day supply or \$20 for a 31- to 100-day supply (Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	\$35 for up to a 30-day supply, \$70 for a 31- to 60-day supply, or \$105 for a 61- to 100-day supply (Deductible doesn't apply)
Most brand-name refills through our mail-order service	\$35 for up to a 30-day supply or \$70 for a 31- to 100-day supply (Deductible doesn't apply)
Durable Medical Equipment	You Pay
The durable medical equipment for home use listed in the "Benefits and Cost Sharing" section in accord with our durable medical equipment formulary guidelines (most durable medical equipment is not covered) .	30% Coinsurance (Deductible doesn't apply)
Mental Health Services	You Pay
Inpatient psychiatric hospitalization (up to 10 days per calendar year)	\$500 per day after Deductible
Outpatient mental health evaluation and treatment:	
Up to a total of 10 individual and group visits per calendar year that include Services for mental health evaluation or treatment	\$30 per individual visit (Deductible doesn't apply) \$15 per group visit (Deductible doesn't apply)
Up to 30 additional group visits in the same calendar year that meet Medical Group criteria	\$15 per visit (Deductible doesn't apply)
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the "Benefits and Cost Sharing" section.	
Chemical Dependency Services	You Pay
Inpatient detoxification	\$500 per day after Deductible
Individual outpatient chemical dependency evaluation and treatment.....	\$30 per visit (Deductible doesn't apply)
Group outpatient chemical dependency treatment	\$5 per visit (Deductible doesn't apply)
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period).....	\$100 per admission after Deductible
Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge (Deductible doesn't apply)
Other	You Pay
Skilled Nursing Facility care (up to 60 days per benefit period).....	\$50 per day after Deductible
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the "Benefits and Cost Sharing" section (most external prosthetic and orthotic devices are not covered)	No charge (Deductible doesn't apply)
Hospice care	No charge (Deductible doesn't apply)

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

Introduction

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

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

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

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

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

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

Term of this Membership Agreement and Evidence of Coverage

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

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

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

Renewal

If you comply with all of the terms of this *Membership Agreement and Evidence of Coverage*, we will automatically renew this *Membership Agreement and Evidence of Coverage* each year, effective on one of the following dates. For any time period that you are continuously enrolled in individuals and families coverage:

- If your initial enrollment was prior to July 1, 2009, your coverage will automatically renew effective on **January 1** of each year
- If your initial enrollment was between January 1 and June 30 of any year, your coverage will automatically renew effective on **January 1** of each year
- If your initial enrollment was between July 1 and December 31 of any year after 2008, your coverage will automatically renew effective on **July 1** of each year

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

Amendment of Membership Agreement and Evidence of Coverage

In accord with "Notices" in the "Miscellaneous Provisions" section, **we may amend this Membership Agreement and Evidence of Coverage (including Premiums and benefits) at any time by sending written notice to the Subscriber at least 60 days before the effective date of the amendment.** The amendment may become effective earlier than the end of the period for which you have already paid your Premiums, and it may require you to pay additional Premiums for that period. All amendments are deemed accepted by the Subscriber unless the Subscriber gives us written notice of non-acceptance within 30 days of the date of the notice, in which case this *Membership Agreement and Evidence of Coverage* terminates the day before the effective date of the amendment.

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

About Kaiser Permanente

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

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

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section

- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Cost Sharing" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits and Cost Sharing" section

Definitions

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

Charges: "Charges" means the following:

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

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

Copayment: A specific dollar amount that you must pay when you receive a covered Service as described in the

"Benefits and Cost Sharing" section. Note: The dollar amount of the Copayment can be \$0 (no charge).

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

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

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

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

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

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

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

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

- A medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services

you receive are Post Stabilization Care and not Emergency Services)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Please refer to *Your Guidebook* for a list of Plan Pharmacies in your area, except that Plan

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

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

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

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

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

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

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

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

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

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

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. For information about Region locations in the

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

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

Northern California Region Service Area

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

- All ZIP codes in Alameda County are inside our Northern California Service Area: 94501–02, 94514, 94536–46, 94550–52, 94555, 94557, 94560, 94566, 94568, 94577–80, 94586–88, 94601–15, 94617–21, 94622–24, 94649, 94659–62, 94666, 94701–10, 94712, 94720, 95377, 95391
- The following ZIP codes in Amador County are inside our Northern California Service Area: 95640, 95669
- All ZIP codes in Contra Costa county are inside our Northern California Service Area: 94505–07, 94509, 94511, 94513–14, 94516–31, 94547–49, 94551, 94553, 94556, 94561, 94563–65, 94569–70, 94572, 94575, 94582–83, 94595–98, 94706–08, 94801–08, 94820, 94850
- The following ZIP codes in El Dorado County are inside our Northern California Service Area: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in Fresno County are inside our Northern California Service Area: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93737, 93740–41, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93786, 93790–94, 93844, 93888
- The following ZIP codes in Kings County are inside our Northern California Service Area: 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in Madera County are inside our Northern California Service Area: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- All ZIP codes in Marin County are inside our Northern California Service Area: 94901, 94903–04, 94912–15, 94920, 94924–25, 94929–30, 94933, 94937–42, 94945–50, 94956–57, 94960, 94963–66, 94970–71, 94973–74, 94976–79
- The following ZIP codes in Mariposa County are inside our Northern California Service Area: 93601, 93623, 93653
- The following ZIP codes in Napa County are inside our Northern California Service Area: 94503, 94508, 94515, 94558–59, 94562, 94567 (except that Knoxville is not in our Northern California Service Area), 94573–74, 94576, 94581, 94589–90, 94599, 95476
- The following ZIP codes in Placer County are inside our Northern California Service Area: 95602–04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95692, 95703, 95722, 95736, 95746–47, 95765
- All ZIP codes in Sacramento County are inside our Northern California Service Area: 94203–09, 94211, 94229–30, 94232, 94234–37, 94239–40, 94244, 94246–50, 94252, 94254, 94256–59, 94261–63, 94267–69, 94271, 94273–74, 94277, 94279–80, 94282–91, 94293–98, 94571, 95608–11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638–41, 95652, 95655, 95660, 95662, 95670–71, 95673, 95680, 95683, 95690, 95693, 95741–42, 95757–59, 95763, 95811–38, 95840–43, 95851–53, 95860, 95864–67, 95894, 95899
- All ZIP codes in San Francisco county are inside our Northern California Service Area: 94102–05, 94107–12, 94114–27, 94129–34, 94137, 94139–47, 94151, 94156, 94158–64, 94172, 94177, 94188
- All ZIP codes in San Joaquin county are inside our Northern California Service Area: 94514, 95201–13, 95215, 95219–20, 95227, 95230–31, 95234, 95236–37, 95240–42, 95253, 95258, 95267, 95269, 95296–97, 95304, 95320, 95330, 95336–37, 95361, 95366, 95376–78, 95385, 95391, 95632, 95686, 95690
- All ZIP codes in San Mateo county are inside our Northern California Service Area: 94002, 94005, 94010–11, 94014–21, 94025–28, 94030, 94037–38, 94044, 94060–66, 94070, 94074, 94080, 94083, 94128, 94303, 94401–04, 94497
- The following ZIP codes in Santa Clara County are inside our Northern California Service Area: 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, 95196

- All ZIP codes in Solano county are inside our Northern California Service Area: 94510, 94512, 94533–35, 94571, 94585, 94589–92, 95616, 95620, 95625, 95687–88, 95690, 95694, 95696
- The following ZIP codes in Sonoma County are inside our Northern California Service Area: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492
- All ZIP codes in Stanislaus county are inside our Northern California Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322–23, 95326, 95328–29, 95350–58, 95360–61, 95363, 95367–68, 95380–82, 95385–87, 95397
- The following ZIP codes in Sutter County are inside our Northern California Service Area: 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95836–37
- The following ZIP codes in Tulare County are inside our Northern California Service Area: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- The following ZIP codes in Yolo County are inside our Northern California Service Area: 95605, 95607, 95612, 95616–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- The following ZIP codes in Yuba County are inside our Northern California Service Area: 95692, 95903, 95961

Southern California Region Service Area

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

- The following ZIP codes in Imperial County are inside our Southern California Service Area: 92274–75
- The following ZIP codes in Kern County are inside our Southern California Service Area: 93203, 93205–06, 93215–16, 93220, 93222, 93224–26, 93238, 93240–41, 93243, 93249–52, 93263, 93268, 93276, 93280, 93285, 93287, 93301–09, 93311–14, 93380, 93383–90, 93501–02, 93504–05, 93518–19, 93531, 93536, 93560–61, 93581
- The following ZIP codes in Los Angeles County are inside our Southern California Service Area: 90001–84, 90086–91, 90093–96, 90099, 90101, 90103, 90189, 90201–02, 90209–13, 90220–24, 90230–33, 90239–42, 90245, 90247–51, 90254–55, 90260–67, 90270, 90272, 90274–75, 90277–78, 90280, 90290–96, 90301–12, 90401–11, 90501–10, 90601–10, 90623, 90630–31, 90637–40, 90650–52, 90660–62,

- 90670–71, 90701–03, 90706–07, 90710–17, 90723, 90731–34, 90744–49, 90755, 90801–10, 90813–15, 90822, 90831–35, 90840, 90842, 90844, 90846–48, 90853, 90895, 90899, 91001, 91003, 91006–12, 91016–17, 91020–21, 91023–25, 91030–31, 91040–43, 91046, 91066, 91077, 91101–10, 91114–18, 91121, 91123–26, 91129, 91182, 91184–85, 91188–89, 91199, 91201–10, 91214, 91221–22, 91224–26, 91301–11, 91313, 91316, 91321–22, 91324–31, 91333–35, 91337, 91340–46, 91350–57, 91361–62, 91364–65, 91367, 91371–72, 91376, 91380–87, 91390, 91392–96, 91401–13, 91416, 91423, 91426, 91436, 91470, 91482, 91495–96, 91499, 91501–08, 91510, 91521–23, 91526, 91601–12, 91614–18, 91702, 91706, 91709, 91711, 91714–16, 91722–24, 91731–35, 91740–41, 91744–50, 91754–56, 91765–73, 91775–76, 91778, 91780, 91788–93, 91795, 91801–04, 91896, 91899, 93243, 93510, 93532, 93534–36, 93539, 93543–44, 93550–53, 93560, 93563, 93584, 93586, 93590–91, 93599
- All ZIP codes in Orange County are inside our Southern California Service Area: 90620–24, 90630–33, 90638, 90680, 90720–21, 90740, 90742–43, 92602–07, 92609–10, 92612, 92614–20, 92623–30, 92637, 92646–63, 92672–79, 92683–85, 92688, 92690–94, 92697–98, 92701–08, 92711–12, 92728, 92735, 92780–82, 92799, 92801–09, 92811–12, 92814–17, 92821–23, 92825, 92831–38, 92840–46, 92850, 92856–57, 92859, 92861–71, 92885–87, 92899
- The following ZIP codes in Riverside County are inside our Southern California Service Area: 91752, 92201–03, 92210–11, 92220, 92223, 92230, 92234–36, 92240–41, 92247–48, 92253–55, 92258, 92260–64, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501–09, 92513–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92589–93, 92595–96, 92599, 92860, 92877–83
- The following ZIP codes in San Bernardino County are inside our Southern California Service Area: 91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758–59, 91761–64, 91766, 91784–86, 91792, 92252, 92256, 92268, 92277–78, 92284–86, 92305, 92307–08, 92313–18, 92321–22, 92324–26, 92329, 92331, 92333–37, 92339–41, 92344–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–95, 92397, 92399, 92401–08, 92410–15, 92418, 92423–24, 92427, 92880
- The following ZIP codes in San Diego County are inside our Southern California Service Area: 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–47, 91950–51, 91962–63, 91976–80, 91987, 92003, 92007–11, 92013–14, 92018–30, 92033, 92037–40,

92046, 92049, 92051–52, 92054–61, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92081–86, 92088, 92091–93, 92096, 92101–24, 92126–32, 92134–40, 92142–43, 92145, 92147, 92149–50, 92152–55, 92158–79, 92182, 92184, 92186–87, 92190–91, 92193, 92195–99

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

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

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

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

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

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

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result

from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

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

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

Premiums, Eligibility, and Enrollment

Premiums

Only Members for whom we have received the appropriate Premiums are entitled to coverage under this *Membership Agreement and Evidence of Coverage*, and then only for the period for which we have received payment. You must prepay the Premiums listed on the Rate Sheet, applicable to your coverage, for each month on or before the last day of the preceding month.

We may amend the Premiums listed on the Rate Sheet upon 60-days prior written notice, as described under "Term and amendment of this *Membership Agreement and Evidence of Coverage*" in the "Introduction" section. Also, your Premiums may change as follows:

- When you add Dependents (other than newborns), drop Dependents, or move to a new rate area, any change in Premiums will take effect at the same time the change in your coverage becomes effective
- When you add a newborn, Premiums for the newborn are effective on the first of the month following birth
- When the Subscriber progresses to a new age band, any change in Premiums will take effect upon renewal

After your first 24 months of individuals and families coverage, we may not increase Premiums solely because you gave us incorrect or incomplete material information in your application for coverage.

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

Continuous enrollment

Coverage under this *Membership Agreement and Evidence of Coverage* is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. This plan is closed to enrollment of new Subscribers, and the Subscriber must have been continuously enrolled under this coverage since March 23, 2010. Subscribers may apply to enroll dependents who meet all of the eligibility requirements in this "Who is Eligible" section.

Eligibility for conversion

The Subscriber and Dependents (except newborns, newly adopted children, and children placed with you or your Spouse for adoption) must have been Members under one of our Group plans at the time of enrollment.

Service Area eligibility requirements

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

If the Subscriber moves from your Home Region to the other California Region, we will transfer the membership of the Subscriber and all Dependents to the Individuals and Families Plan in that Region that is most similar to this plan. All terms and conditions in your Health Coverage Application, including the Conditions of Acceptance and Arbitration Agreement, will continue to apply. We will provide the Subscriber with the effective

date of coverage and a Kaiser Permanente ID card for each Member of the Family with a new medical record number on it. Please refer to the Rate Sheet for the premiums that apply in the other California Region. For more information, please call our Member Service Call Center.

If the Subscriber moves to the service area of a Region outside California, you may be able to apply for membership in that Region by contacting the member or customer service department there, but the plan, including coverage, premiums, and eligibility requirements, might not be the same. For the purposes of this eligibility rule, the service areas of the Regions outside California may change on January 1 of each year and are currently the District of Columbia and parts of Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington. For more information, please call our Member Service Call Center.

If the Subscriber moves anywhere else outside your Home Region 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 your Home Region Service Area, except as described in the sections listed below for the following Services:

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

Additional eligibility requirements

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

- Your Spouse. For the purposes of this *Membership Agreement and Evidence of Coverage*, the term "Spouse" includes the Subscriber's same-sex spouse if the Subscriber and spouse are a couple who meet all of the requirements of Section 308(c) of the California Family Code or your registered domestic partner who meets all of the requirements of Sections 297 or 299.2 of the California Family Code, or your domestic partner as determined by Health Plan
- Your or your Spouse's children (including adopted children or children placed with you or your Spouse for adoption) who are under age 26

- Children (not including foster children) for whom you or your Spouse is the court-appointed guardian (or was when the person reached age 18) if they are under age 26
- Children whose parent is a Dependent under your family coverage (including adopted children or children placed with your Dependent for adoption, but not including foster children) if they meet all of the following requirements:
 - ◆ they are not married and do not have a domestic partner (for the purposes of this requirement only, "domestic partner" means someone who is a registered domestic partner in California or who is legally recognized as a domestic partner in the state where the couple resides)
 - ◆ they are under age 26
 - ◆ they receive all of their support and maintenance from you or your Spouse
 - ◆ they permanently reside with you or your Spouse
- Dependents who meet the Dependent eligibility requirements, except for the age limit, are eligible as disabled dependents if they meet all of the following requirements:
 - ◆ they are your or your Spouse's children, your or your Spouse's adopted children, children placed with you or your Spouse for adoption, or children for whom you or your Spouse is the legal guardian
 - ◆ they are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached age 26
 - ◆ they receive 50 percent or more of their support and maintenance from you or your Spouse
 - ◆ you give us proof of their incapacity and dependency within 60 days after we request it (see "Disabled dependent certification" below in this "Additional eligibility requirements" section)

Disabled dependent certification. One of the requirements for a dependent to be eligible for membership as a disabled dependent is that the Subscriber must provide us documentation of the dependent's incapacity and dependency as follows:

- If the Dependent is a Member, we will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent's incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as a disabled dependent. If

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

- If the dependent is not a Member and the Subscriber is requesting enrollment, the Subscriber must provide us documentation of the dependent's incapacity and dependency within 60 days after we request it so that we can determine if the dependent is eligible to enroll as a disabled dependent. If we determine that the dependent is eligible as a disabled dependent, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as a disabled dependent

Members with Medicare

This *Membership Agreement and Evidence of Coverage* is not intended for most Medicare beneficiaries. If, during the term of this *Membership Agreement and Evidence of Coverage*, 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 if you are eligible to enroll in the plan and the plan is available to you.

Capacity limit. You may be ineligible to enroll in Kaiser Permanente Senior Advantage if that plan has reached a capacity limit that the Centers for Medicare & Medicaid Services has approved. This limitation does not apply if you are currently a Health Plan Member in the Northern California or Southern California Region who is eligible for Medicare (for example, when you turn age 65).

Medicare late enrollment penalties. If you become eligible for Medicare Part B and do not enroll, Medicare may require you to pay a late enrollment penalty if you later enroll in Medicare Part B. However, if you delay enrollment in Part B because you or your husband or wife are still working and have coverage through an

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

How to Enroll

This plan is closed to enrollment of new Subscribers. The Subscriber may be able to enroll dependents as described in this "How to Enroll" section.

Adding a new dependent child to an existing account

To enroll a newborn, newly adopted child, or child placed with you or your Spouse for adoption who becomes eligible to enroll after you became a Kaiser Permanente Individual—Conversion Deductible 30/1500 Plan Subscriber, you must submit an enrollment form within 31 days after the child first becomes eligible.

Changing your benefit plan

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

Effective date of coverage

If we approve your enrollment application, we will notify you of the date your coverage will begin (membership begins at the beginning [12:00 a.m.] of the effective date specified in our notice). When you add a newborn or newly adopted child to your Family, the effective date of coverage is as follows:

- For a newborn child, coverage is effective from the moment of birth. However, if you do not enroll the newborn child within 31 days, the newborn is covered for only 31 days (including the date of birth)
- For a newly adopted child or a child placed with you or your Spouse for adoption, coverage is effective on the date when you or your Spouse gain the legal right to control the child's health care. For purposes of this

requirement, "legal right to control health care" means you have a signed written document (such as a health facility minor release report, a medical authorization form, or a relinquishment form) or other evidence that shows you or your Spouse have the legal right to control the child's health care

How to Obtain Services

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

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

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

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

Routine Care

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

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

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

Urgent Care

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

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

Not Sure What Kind of Care You Need?

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

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

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

Your Personal Plan Physician

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

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

personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians.

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

Getting a Referral

Referrals to Plan Providers

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

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

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

Medical Group authorization procedure for certain referrals

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

- **Durable medical equipment.** If your Plan Physician prescribes durable medical equipment, he or she will submit a written referral to the Plan Hospital's durable medical equipment coordinator, who will authorize the durable medical equipment if he or she determines that your durable medical equipment coverage includes the item and that the item is listed on our formulary for your condition. If the item doesn't appear to meet our durable medical equipment formulary guidelines, then the durable medical equipment coordinator will contact the Plan Physician for additional information. If the durable medical

equipment request still doesn't appear to meet our durable medical equipment formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our durable medical equipment formulary, please refer to "Durable Medical Equipment for Home Use" in the "Benefits and Cost Sharing" section

- **Ostomy and urological supplies.** If your Plan Physician prescribes ostomy or urological supplies, he or she will submit a written referral to the Plan Hospital's designated coordinator, who will authorize the item if he or she determines that it is covered and the item is listed on our soft goods formulary for your condition. If the item doesn't appear to meet our soft goods formulary guidelines, then the coordinator will contact the Plan Physician for additional information. If the request still doesn't appear to meet our soft goods formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our soft goods formulary, please refer to "Ostomy and Urological Supplies" in the "Benefits and Cost Sharing" section
- **Services not available from Plan Providers.** If your Plan Physician decides that you require covered Services not available from Plan Providers, he or she will recommend to the Medical Group that you be referred to a Non-Plan Provider inside or outside your Home Region Service Area. The appropriate Medical Group designee will authorize the Services if he or she determines that they are Medically Necessary and are not available from a Plan Provider. Referrals to Non-Plan Physicians will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your Plan Physician what Services have been authorized
- **Transplants.** If your Plan Physician makes a written referral for a transplant, the Medical Group's regional transplant advisory committee or board (if one exists) will authorize the Services if it determines that they are Medically Necessary. In cases where no transplant committee or board exists, the Medical Group will refer 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 of the information (including additional examination and test results) reasonably necessary to make the decision, except that decisions about urgent Services will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If the Medical Group needs more time to make the decision because it doesn't have information reasonably necessary to make the decision, or because it has requested consultation by a particular specialist, you and your treating physician will be informed about the additional information, testing, or specialist that is needed, and the date that the Medical Group expects to make a decision.

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

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

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

Second Opinions

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

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

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

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

Contracts with Plan Providers

How Plan Providers are paid

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

Financial liability

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

Breach of contract

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

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

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

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

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

- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Care for children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the termination date of the terminated provider, or (2) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of the termination date of the terminated provider

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

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

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

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

Visiting Other Regions

If you visit the service area of another Region temporarily (not more than 90 days), you can receive visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting member care and your out-

of-pocket costs may differ from the covered Services and Cost Sharing described in this *Membership Agreement and Evidence of Coverage*.

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

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

Your ID Card

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

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

Getting Assistance

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

Member Services

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Call Center representatives are

available to assist you weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays) toll free at 1-800-464-4000 or 1-800-777-1370 (TTY for the deaf, hard of hearing, or speech impaired). For your convenience, you can also contact us through our website at **kp.org**.

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

If you have questions about a bill or about how much you have paid toward your Deductible or annual out-of-pocket maximum, or to get an estimate of Charges for Services that are subject to the Deductible, please call our Member Service Call Center weekdays from 7 a.m. to 5 p.m. toll free at 1-800-390-3507 (TTY users call 1-800-777-1370). You can also get an estimate of Charges for Services through our website at **kp.org**.

Interpreter services

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

Plan Facilities

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

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

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

Plan Hospitals and Plan Medical Offices

The following is a list of Plan Hospitals and most Plan Medical Offices in the Service Area of our Northern California and Southern California Regions. As a Member, you are enrolled in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), called your Home Region. The coverage information in this *Membership Agreement and Evidence of Coverage* applies when you obtain care in your Home Region. When you visit the other California Region, you may receive care from Plan Facilities in that Region as described in "Visiting Other Regions" in the "How to Obtain Services" section.

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

Northern California Region Plan Facilities

Alameda

- Medical Offices: 2417 Central Ave.

Antioch

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

Campbell

- Medical Offices: 220 E. Hacienda Ave.

Clovis

- Medical Offices: 2071 Herndon Ave.

Daly City

- Medical Offices: 395 Hickey Blvd.

Davis

- Medical Offices: 1955 Cowell Blvd.

Elk Grove

- Medical Offices: 9201 Big Horn Blvd.

Fairfield

- Medical Offices: 1550 Gateway Blvd.

Folsom

- Medical Offices: 2155 Iron Point Rd.

Fremont

- Hospital and Medical Offices: 39400 Paseo Padre Pkwy.

Fresno

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

Gilroy

- Medical Offices: 7520 Arroyo Circle

Hayward

- Hospital and Medical Offices: 27400 Hesperian Blvd.

Lincoln

- Medical Offices: 1900 Dresden Dr.

Livermore

- Medical Offices: 3000 Las Positas Rd.

Manteca

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

Martinez

- Medical Offices: 200 Muir Rd.

Milpitas

- Medical Offices: 770 E. Calaveras Blvd.

Modesto

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

Mountain View

- Medical Offices: 555 Castro St.

Napa

- Medical Offices: 3285 Claremont Way

Novato

- Medical Offices: 97 San Marin Dr.

Oakhurst

- Medical Offices: 40595 Westlake Dr.

Oakland

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

Petaluma

- Medical Offices: 3900 Lakeville Hwy.

Pinole

- Medical Offices: 1301 Pinole Valley Rd.

Pleasanton

- Medical Offices: 7601 Stoneridge Dr.

Rancho Cordova

- Medical Offices: 10725 International Dr.

Redwood City

- Hospital and Medical Offices: 1150 Veterans Blvd.

Richmond

- Hospital and Medical Offices: 901 Nevin Ave.

Rohnert Park

- Medical Offices: 5900 State Farm Dr.

Roseville

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

Sacramento

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

San Bruno

- Medical Offices: 901 El Camino Real

San Francisco

- Hospital and Medical Offices: 2425 Geary Blvd.

San Jose

- Hospital and Medical Offices: 250 Hospital Pkwy.

San Mateo

- Medical Offices: 1000 Franklin Pkwy.

San Rafael

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

Santa Clara

- Hospital and Medical Offices: 700 Lawrence Expwy.

Santa Rosa

- Hospital and Medical Offices: 401 Bicentennial Way

Selma

- Medical Offices: 2651 Highland Ave.

South San Francisco

- Hospital and Medical Offices: 1200 El Camino Real

Stockton

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

Tracy

- Medical Offices: 2185 W. Grant Line Rd.

Turlock

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

Union City

- Medical Offices: 3553 Whipple Rd.

Vacaville

- Hospital and Medical Offices: 1 Quality Dr.

Vallejo

- Hospital and Medical Offices: 975 Sereno Dr.

Walnut Creek

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

Southern California Region Plan Facilities

Aliso Viejo

- Medical Offices: 24502 Pacific Park Dr.

Anaheim

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

Bakersfield

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

Baldwin Park

- Hospital and Medical Offices: 1011 Baldwin Park Blvd.

Bellflower

- Medical Offices: 9400 E. Rosecrans Ave.

Bonita

- Medical Offices: 3955 Bonita Rd.

Brea

- Medical Offices: 1900 E. Lambert Rd.

Camarillo

- Medical Offices: 2620 E. Las Posas Rd.

Carlsbad

- Medical Offices: 6860 Avenida Encinas

Chino

- Medical Offices: 11911 Central Ave.

Claremont

- Medical Offices: 250 W. San Jose St.

Colton

- Medical Offices: 789 S. Cooley Dr.

Corona

- Medical Offices: 2055 Kellogg Ave.

Cudahy

- Medical Offices: 7825 Atlantic Ave.

Culver City

- Medical Offices: 5620 Mesmer Ave.

Diamond Bar

- Medical Offices: 1336 Bridge Gate Dr.

Downey

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

El Cajon

- Medical Offices: 1630 E. Main St.

Escondido

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

Fontana

- Hospital and Medical Offices: 9961 Sierra Ave.

Garden Grove

- Medical Offices: 12100 Euclid St.

Gardena

- Medical Offices: 15446 S. Western Ave.

Glendale

- Medical Offices: 444 W. Glenoaks Blvd.

Harbor City

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

Huntington Beach

- Medical Offices: 18081 Beach Blvd.

Indio

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

Inglewood

- Medical Offices: 110 N. La Brea Ave.

Irvine

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

Joshua Tree

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

La Mesa

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

La Palma

- Medical Offices: 5 Centerpointe Dr.

Lancaster

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

Long Beach

- Medical Offices: 3900 E. Pacific Coast Hwy.

Los Angeles

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

Lynwood

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

Mission Hills

- Medical Offices: 11001 Sepulveda Blvd.

Mission Viejo

- Medical Offices: 23781 Maquina Ave.

Montebello

- Medical Offices: 1550 Town Center Dr.

Moreno Valley

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

Murrieta

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

Oceanside

- Medical Offices: 3609 Ocean Ranch Blvd.

Ontario

- Medical Offices: 2295 S. Vineyard Ave.

Oxnard

- Medical Offices: 2200 E. Gonzales Rd.

Palm Desert

- Medical Offices: 75-036 Gerald Ford Dr.

Palm Springs

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

Palmdale

- Medical Offices: 4502 E. Avenue S

Panorama City

- Hospital and Medical Offices: 13652 Cantara St.

Pasadena

- Medical Offices: 3280 E. Foothill Blvd.

Rancho Cucamonga

- Medical Offices: 10850 Arrow Rte.

Redlands

- Medical Offices: 1301 California St.

Riverside

- Hospital and Medical Offices: 10800 Magnolia Ave.

San Bernardino

- Medical Offices: 1717 Date Pl.

San Diego

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

San Dimas

- Medical Offices: 1255 W. Arrow Hwy.

San Juan Capistrano

- Medical Offices: 30400 Camino Capistrano

San Marcos

- Medical Offices: 400 Craven Rd.

Santa Ana

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

Santa Clarita

- Medical Offices: 27107 Tourney Rd.

Simi Valley

- Medical Offices: 3900 Alamo St.

Temecula

- Medical Offices: 27309 Madison Ave.

Thousand Oaks

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

Torrance

- Medical Offices: 20790 Madrona Ave.

Upland

- Medical Offices: 1183 E. Foothill Blvd.

Ventura

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

Victorville

- Medical Offices: 14011 Park Ave.

West Covina

- Medical Offices: 1249 Sunset Ave.

Whittier

- Medical Offices: 12470 Whittier Blvd.

Wildomar

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

Woodland Hills

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

Yorba Linda

- Medical Offices: 22550 E. Savi Ranch Pkwy.

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

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

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

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

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital Emergency Department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non-Plan Providers anywhere in the world as long as the Services would have been covered under the "Benefits and Cost

Sharing" section (subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section) if you had received them from Plan Providers.

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

Post-Stabilization Care

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

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

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

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

possible, you increase the risk that you will have to pay for this care.

Cost Sharing

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

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

Services not covered under this "Emergency Services" section

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

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

Urgent Care

Inside the Service Area

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

Out-of-Area Urgent Care

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

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

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

Cost Sharing

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

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

Services not covered under this "Urgent Care" section

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

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

Payment and Reimbursement

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

Provider as part of covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy.

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

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

How to file a claim

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

- As soon as possible, send us a completed claim form. You can get a claim form by visiting our website at **kp.org** or by calling our Member Service Call Center toll free at 1-800-464-4000 or 1-800-390-3510 (TTY users call 1-800-777-1370). One of our representatives will be happy to assist you if you need help completing our claim form
- If you have paid for Services, you must include any bills and receipts from the Non–Plan Provider with your claim form
- To request that we pay a Non–Plan Provider for Services, you must include any bills from the Non–Plan Provider with your claim form. If the Non–Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the Non–Plan Provider for covered Services (other than bills for your Cost Sharing amount), please call our Member Service Call Center toll free at 1-800-390-3510 for assistance

- The completed claim form and any bills or receipts must be mailed to the following address as soon as possible after receiving the care:

For Northern California Members:

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

For Southern California Members:

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

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

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

Benefits and Cost Sharing

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

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
 - ◆ health care items and services for preventive care
 - ◆ health care items and services for diagnosis, assessment, or treatment

- ◆ health education covered under "Health Education" in this "Benefits and Cost Sharing" section
- ◆ other health care items and services
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the sections listed below for the following Services:
 - ◆ drugs prescribed by dentists as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section
 - ◆ emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
 - ◆ Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- You receive the Services from Plan Providers inside your Home Region Service Area, except where specifically noted to the contrary in the sections listed below for the following Services:
 - ◆ authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
 - ◆ emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
 - ◆ Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
 - ◆ hospice care as described under "Hospice Care" in this "Benefits and Cost Sharing" section
- The Medical Group has given prior authorization for the Services if required under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

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

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

Cost Sharing

General rules, examples, and exceptions

Your Cost Sharing for covered Services will be the Cost Sharing in effect on the date you receive the Services, except as follows:

- If you are receiving covered inpatient hospital or Skilled Nursing Facility Services on the effective date of this *Membership Agreement and Evidence of Coverage*, you pay the Cost Sharing in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Sharing in effect on the date you receive the Services
 - For items ordered in advance, you pay the Cost Sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription
- additional unscheduled Services, in addition to the Cost Sharing amount you paid at check-in for the treatment of your existing condition
 - You receive Services from a second provider during your visit that were not scheduled when you made your payment at check-in. For example, if you are scheduled to receive a diagnostic exam, at check-in we will ask you to pay the Cost Sharing that applies to these Services. If during your diagnostic exam your provider confirms a problem with your health, your provider may request the assistance of another provider to perform additional unscheduled Services (such as an outpatient procedure). You may have to pay separate Cost Sharing amounts for the unscheduled Services of the second provider, in addition to the Cost Sharing amount you paid at check-in for your diagnostic exam
 - You go in for Preventive Care Services and receive non-preventive Services during your visit that were not scheduled when you made your payment at check-in. For example, if you go in for a routine physical maintenance exam, at check-in we will ask you to pay the Cost Sharing that applies to these Services (the Cost Sharing may be "no charge"). If during your routine physical maintenance exam your provider finds a problem with your health, your provider may order non-preventive Services to diagnose your problem (such as laboratory tests). You may have to pay separate Cost Sharing amounts for the non-preventive Services performed to diagnose your problem, in addition to the Cost Sharing amount you paid at check-in for your routine physical maintenance exam
 - You request at check-in that we bill you for some or all of the Cost Sharing for the Services you will receive, and we agree to bill you

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

- You receive Services during your visit that were not scheduled when you made your payment at check-in. For example, if you are scheduled to receive treatment for an existing condition, at check-in we will ask you to pay the Cost Sharing that applies to these Services. If during your visit your provider finds another problem with your health, your provider may perform or order additional unscheduled Services to diagnose your problem. You may have to pay separate Cost Sharing amounts for each of these

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

For more information about Cost Sharing. If you have questions about Cost Sharing for specific Services that you are scheduled to receive or that your provider orders during a visit or procedure, please visit our website at kp.org/memberestimates to use our Cost Sharing estimate tool or call our Member Service Call Center weekdays 7 a.m. to 5 p.m. toll free at 1-800-390-3507 (TTY users call 1-800-777-1370).

Noncovered Services. If you receive Services that are not covered under this *Membership Agreement and*

Evidence of Coverage, you may be liable for the full price of those Services. Payments you make for noncovered Services are not Cost Sharing.

Deductibles

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

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

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

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. The Cost Sharing that you must pay for covered Services is in this "Benefits and Cost Sharing" section and "Chiropractic Services Amendment." When the Cost Sharing is described as "subject to the Deductible," and you have not met the Deductible, you must pay Charges for those Services. Note: When we cover Services at "no charge" subject to the Deductible and you have not met your Deductible, you must pay Charges for the Services.

If you would like an estimate of the Charges for a Service before you schedule an appointment or procedure, please visit our website at kp.org/memberestimates to use our Cost Sharing estimate tool or call our Member Service Call Center weekdays 7 a.m. to 5 p.m. toll free at 1-800-390-3507 (TTY users call 1-800-777-1370). Note: If you pay a Deductible amount for a Service that has a visit limit, the Services count toward reaching the limit.

After you receive the Services, we will send you a bill that lists Charges for the Services you received,

payments and credits applied to your account, and any amounts you still owe. You may receive more than one bill for a single outpatient visit or hospital stay. For example, you may receive a one bill for physician services and a separate bill for hospital services. In addition, it may take more than one bill to reflect all of the Services you received. If we determine that you overpaid and are due a refund, then we will send a refund to you within 4 weeks after we make that determination.

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 Summary of Accumulation. The Summary of Accumulation will include the total amount you have paid toward your Deductible and toward your annual out-of-pocket maximum. You can also obtain a copy of this Summary of Accumulation from our Member Service Call Center weekdays 7 a.m. to 5 p.m. toll free at 1-800-390-3507 (TTY users call 1-800-777-1370). Any overpayments will be refunded to you.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service (after you meet any applicable Deductible) is described in this "Benefits and Cost Sharing" section.

Annual out-of-pocket maximum

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

- **\$3,500** per calendar year for self-only enrollment (a Family of one Member)
- **\$3,500** per calendar year for any one Member in a Family of two or more Members
- **\$7,000** per calendar year for an entire Family of two or more Members

If you are a Member in a Family of two or more Members, you reach the annual out-of-pocket maximum either when you meet the maximum for any one Member, or when your Family reaches the Family maximum. For example, suppose you have reached the **\$3,500** maximum. For Services subject to the maximum, you will not pay any more Cost Sharing during the rest of the calendar year, but every other Member in your Family must continue to pay Cost Sharing during the calendar year until your Family reaches the **\$7,000** maximum.

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

- Administered drugs
- Ambulance Services
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)
- Diabetic testing supplies and equipment and insulin-administration devices
- Emergency Department visits
- Home health care
- Hospice care
- Hospital care, except that for mental health hospital care, the only care that counts is care for these mental health conditions:
 - ◆ Serious Emotional Disturbances of a child described under "Mental Health Services" in this "Benefits and Cost Sharing" section
 - ◆ these Severe Mental Illnesses: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa
- Imaging, laboratory, and special procedures
- Intensive psychiatric treatment programs
- Outpatient surgery
- Prosthetic and orthotic devices
- Services performed during an office visit (including professional Services such as dialysis treatment, health education counseling and programs, and physical, occupational, and speech therapy). However, chemical dependency and chiropractic consultations and treatment do not count toward the maximum, and the only mental health Services that count toward the maximum are Services for these mental health conditions:
 - ◆ Serious Emotional Disturbances of a child described under "Mental Health Services" in this "Benefits and Cost Sharing" section
 - ◆ these Severe Mental Illnesses: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder,

pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa

- Skilled Nursing Facility care

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

Keeping track of the maximum. When you pay Cost Sharing that applies toward the annual out-of-pocket maximum, we will give you a receipt and we will send you a Summary of Accumulation. The Summary of Accumulation will include the total amounts you have paid toward your Deductible and toward your annual out-of-pocket maximum. You can also obtain a copy of this Summary of Accumulation from our Member Service Call Center weekdays 7 a.m. to 5 p.m. toll free at 1-800-390-3507 (TTY users call 1-800-777-1370).

Preventive Care Services

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

The following Services are not subject to the Deductible when they are Preventive Care Services (if you receive other Services during a visit that includes Preventive Care Services, those other Services may be subject to the Deductible):

- Eye exams for refraction and preventive vision screenings
- Family planning counseling and programs
- Flexible sigmoidoscopies
- Health education counseling and programs
- Hearing exams and screenings
- Immunizations (including the vaccine) administered in a Plan Medical Office

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

Outpatient Care

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

- Primary and specialty care consultations, exams, and treatment (other than those described below in this "Outpatient Care" section): **a \$30 Copayment per visit (not subject to the Deductible)**
- Preventive Care Services:
 - ◆ routine physical maintenance exams, including well-woman exams: **a \$30 Copayment per visit (not subject to the Deductible)**
 - ◆ well-child preventive exams for Members through age 23 months: **a \$30 Copayment per visit (not subject to the Deductible)**
 - ◆ family planning counseling, or consultations to obtain internally implanted time-release contraceptives or intrauterine devices (IUDs) prescribed in accord with our drug formulary guidelines: **a \$30 Copayment per visit (not subject to the Deductible)**
 - ◆ after confirmation of pregnancy, the normal series of regularly scheduled preventive prenatal care exams and the first postpartum follow-up consultation and exam: **a \$30 Copayment per visit (not subject to the Deductible)**
- ◆ alcohol and substance abuse screenings: **no charge (not subject to the Deductible)**
- ◆ developmental screenings to diagnose and assess potential developmental delays: **no charge (not subject to the Deductible)**
- ◆ immunizations (including the vaccine) administered to you in a Plan Medical Office: **no charge (not subject to the Deductible)**
- ◆ flexible sigmoidoscopies: **a \$30 Copayment per visit (not subject to the Deductible)**
- Allergy injections (including allergy serum): **a \$5 Copayment per visit subject to the Deductible**
- Outpatient surgery: **a \$250 Copayment per procedure subject to the Deductible** if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Any other outpatient surgery is covered at a **\$30 Copayment per procedure (not subject to the Deductible)**
- Outpatient procedures (other than surgery): **a \$250 Copayment per procedure subject to the Deductible** if a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. All outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above are covered **at the Cost Sharing that would otherwise apply for the procedure** in this "Benefits and Cost Sharing" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Special Procedures")
- Voluntary termination of pregnancy: **a \$30 Copayment per procedure subject to the Deductible**
- Physical, occupational, and speech therapy: **a \$30 Copayment per visit subject to the Deductible**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program: **a \$30 Copayment per day subject to the Deductible**
- Urgent Care consultations, exams, and treatment: **a \$30 Copayment per visit (not subject to the Deductible)**
- Emergency Department visits: **a \$150 Copayment per visit subject to the Deductible**. After you meet

the Deductible, the Emergency Department Copayment does not apply if you are admitted directly to the hospital as an inpatient for covered Services, or if you are admitted for observation and are then admitted directly to the hospital as an inpatient for covered Services (for inpatient care, please refer to "Hospital Inpatient Care" in this "Benefits and Cost Sharing" section). However, after you meet the Deductible, the Emergency Department Copayment does apply if you are admitted for observation but are not admitted as an inpatient

- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside your Home Region Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge (not subject to the Deductible)**
- Acupuncture Services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain): **a \$30 Copayment per visit (not subject to the Deductible)**
- Blood, blood products, and their administration: **no charge subject to the Deductible**
- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in a Plan Medical Office or during home visits: **no charge (not subject to the Deductible)**
- Some types of outpatient consultations, exams, and treatment may be available as group appointments, which we cover at **a \$15 Copayment per visit (not subject to the Deductible)**

Services not covered under this "Outpatient Care" section

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

- Bariatric Surgery
- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Durable Medical Equipment for Home Use
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care

- Mental Health Services
- Ostomy and Urological Supplies
- Outpatient Imaging, Laboratory, and Special Procedures
- Outpatient Prescription Drugs, Supplies, and Supplements
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Transplant Services
- Vision Services

Hospital Inpatient Care

We cover the following inpatient Services at a **\$500 Copayment per day subject to the Deductible** in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals inside your Home Region Service Area:

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

- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program)
- Respiratory therapy
- Medical social services and discharge planning

Services not covered under this "Hospital Inpatient Care" section

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

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

Ambulance Services

Emergency

We cover at a **\$150 Copayment per trip subject to the Deductible** Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

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

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

Nonemergency

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

Ambulance Services exclusion

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

Bariatric Surgery

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

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

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

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

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

Services not covered under this "Bariatric Surgery" section

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

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

Chemical Dependency Services

Inpatient detoxification

We cover hospitalization at a **\$500 Copayment per day subject to the Deductible** in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Outpatient chemical dependency care

We cover the following Services for treatment of chemical dependency:

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

You pay the following for these covered Services:

- Individual chemical dependency evaluation and treatment: **a \$30 Copayment per visit (not subject to the Deductible)**
- Group chemical dependency treatment: **a \$5 Copayment per visit (not subject to the Deductible)**

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

Transitional residential recovery Services

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

Services not covered under this "Chemical Dependency Services" section

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

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

Chemical dependency Services exclusion

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

Dental and Orthodontic Services

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

Dental Services for radiation treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for

radiation therapy of cancer in your head or neck 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.

Dental and orthodontic Services for cleft palate

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

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

Cost Sharing for dental and orthodontic Services

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

- Hospital inpatient care: **a \$500 Copayment per day subject to the Deductible**
- Outpatient consultations, exams, and treatment: **a \$30 Copayment per visit (not subject to the Deductible)**
- Outpatient surgery: **a \$250 Copayment per procedure subject to the Deductible** if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your

vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Any other outpatient surgery is covered at a **\$30 Copayment per procedure (not subject to the Deductible)**

- Outpatient procedures (other than surgery): **a \$250 Copayment per procedure subject to the Deductible** if a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. All outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above are covered **at the Cost Sharing that would otherwise apply for the procedure** in this "Benefits and Cost Sharing" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Special Procedures")

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

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

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

Dialysis Care

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

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

After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside your Home Region Service Area at **no charge subject to the Deductible**.

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

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

- Inpatient dialysis care: **a \$500 Copayment per day subject to the Deductible**
- One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, exam, or treatment: **no charge (not subject to the Deductible)**
- All other outpatient consultations, exams, and treatment: **a \$30 Copayment per visit (not subject to the Deductible)**
- Hemodialysis treatment at a Plan Facility: **a \$30 Copayment per visit subject to the Deductible**

Services not covered under this "Dialysis Care" section

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

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

Dialysis Care exclusions

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

Durable Medical Equipment for Home Use

Inside your Home Region Service Area, we cover the durable medical equipment specified in this "Durable Medical Equipment for Home Use" section for use in your home (or another location used as your home) in accord with our durable medical equipment formulary guidelines. Durable medical equipment for home use is

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

Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered durable medical equipment (including repair or replacement of covered equipment, unless due to loss or misuse) is provided at **30% Coinsurance (not subject to the Deductible)**. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

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

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

Outside the Service Area

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

- Standard curved handle cane

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

About our durable medical equipment formulary

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

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

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

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

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

Durable medical equipment for home use exclusion

- Comfort, convenience, or luxury equipment or features

Health Education

We cover a variety of health education counseling, programs, and materials that your personal Plan Physician or other Plan Providers provide during a visit covered under another part of this "Benefits and Cost Sharing" section.

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

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

You pay the following for these covered Services:

- Covered health education programs, which may include programs provided online and counseling over the phone: **no charge (not subject to the Deductible)**
- Individual counseling during an office visit related to smoking cessation: **no charge (not subject to the Deductible)**
- Individual counseling during an office visit related to diabetes management: **a \$30 Copayment per visit (not subject to the Deductible)**
- Other covered individual counseling when the office visit is solely for health education: **a \$30 Copayment per visit (not subject to the Deductible)**
- Health education provided during an outpatient consultation or exam covered in another part of this "Benefits and Cost Sharing" section: **no additional Cost Sharing beyond the Cost Sharing required in that other part of this "Benefits and Cost Sharing" section**

- Covered health education materials: **no charge (not subject to the Deductible)**

Hearing Services

We do not cover hearing aids (other than internally-implanted devices as described in the "Prosthetic and Orthotic Devices" section). However, we do cover the following:

- Routine hearing screenings that are Preventive Care Services: **no charge (not subject to the Deductible)**
- Hearing exams to determine the need for hearing correction: **a \$30 Copayment per visit (not subject to the Deductible)**

Services not covered under this "Hearing Services" section

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

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

Hearing Services exclusions

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

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover home health care at **no charge (not subject to the Deductible)** only if all of the following are true:

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

care in your home and that the Services can be safely and effectively provided in your home

- The Services are provided inside your Home Region Service Area

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

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

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

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

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

Home health care exclusions

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

Hospice Care

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

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

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

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

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from Plan Pharmacies. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please

call our Member Service Call Center for the current list of these drugs)

- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling
- The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms:
 - ◆ nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
 - ◆ short-term inpatient care required at a level that cannot be provided at home

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM)* that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the *DSM* identifies as something other than a "mental disorder." For example, the *DSM* identifies relational problems as something other than a "mental disorder," so we do not cover services (such as couples counseling or family counseling) for relational problems.

"Mental Disorders" include the following conditions:

- Severe Mental Illness of a person of any age. "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa
- A Serious Emotional Disturbance of a child under age 18. A "Serious Emotional Disturbance" of a child under age 18 means a condition identified as a "mental disorder" in the *DSM*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the

child also meets at least one of the following three criteria:

- ◆ as a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
- ◆ the child displays psychotic features, or risk of suicide or violence due to a mental disorder
- ◆ the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

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

Outpatient mental health Services

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

- Up to a combined visit limit of 10 individual and group visits per Member per calendar year that include Services for mental health evaluation and treatment as described in this "Outpatient mental health Services" section. Members who have exhausted the 10-visit limit and who meet Medical Group criteria may receive up to 30 additional group visits in the same calendar year. These visit limits do not apply to mental health Services for Severe Mental Illness of a person of any age or Serious Emotional Disturbance of a child under age 18
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

You pay the following for these covered Services:

- Individual mental health evaluation and treatment: a **\$30 Copayment per visit (not subject to the Deductible)**

- Group mental health treatment: a **\$15 Copayment per visit (not subject to the Deductible)**

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

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs

Inpatient psychiatric hospitalization. Subject to the day limit described under "Calendar-year day limit for inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in this "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" section, we cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license. We cover these Services at a **\$500 Copayment per day subject to the Deductible**.

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

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

Calendar-year day limit for inpatient psychiatric hospitalization and intensive psychiatric treatment programs. There is a combined day limit of 10 days per Member per calendar year for psychiatric care described under "Inpatient psychiatric hospitalization" and "Intensive psychiatric treatment programs" in this "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" section, except that the day limit does not apply to mental health Services for Severe Mental Illnesses of a person of any age or Serious

Emotional Disturbance of a child under age 18. The number of days is determined by adding up the number of days of inpatient psychiatric hospitalization and intensive psychiatric treatment program Services we cover in a calendar year that are subject to the limit as follows:

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

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

Services not covered under this "Mental Health Services" section

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

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

Ostomy and Urological Supplies

Inside your Home Region Service Area, we cover ostomy and urological supplies prescribed in accord with our soft goods formulary guidelines at **no charge (not subject to the Deductible)**. We select the vendor, and coverage is limited to the standard supply that adequately meets your medical needs.

About our soft goods formulary

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

included in our soft goods formulary, please call our Member Service Call Center.

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

Ostomy and urological supplies exclusion

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Special Procedures

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

- Imaging Services that are Preventive Care Services:
 - ◆ preventive mammograms: **a \$10 Copayment per encounter (not subject to the Deductible)**
 - ◆ preventive aortic aneurysm screenings: **a \$10 Copayment per encounter (not subject to the Deductible)**
 - ◆ bone density CT scans: **a \$50 Copayment per procedure subject to the Deductible**
 - ◆ bone density DEXA scans: **a \$10 Copayment per encounter subject to the Deductible**
- All other CT scans, and all MRIs and PET scans: **a \$50 Copayment per procedure subject to the Deductible**
- All other imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds: **a \$10 Copayment per encounter subject to the Deductible** except that certain imaging procedures are covered at **a \$250 Copayment per procedure subject to the Deductible** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
- Nuclear medicine: **a \$10 Copayment per encounter subject to the Deductible**

- Laboratory tests:
 - ◆ laboratory tests to monitor the effectiveness of dialysis: **no charge subject to the Deductible**
 - ◆ fecal occult blood tests: **no charge (not subject to the Deductible)**
 - ◆ routine laboratory tests and screenings that are Preventive Care Services, such as preventive cervical cancer screenings, prostate specific antigen tests, cholesterol tests (lipid panel and profile), diabetes screening (fasting blood glucose tests), certain sexually transmitted disease (STD) tests, and HIV tests: **a \$10 Copayment per encounter (not subject to the Deductible)**
 - ◆ all other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available): **a \$10 Copayment per encounter subject to the Deductible**
- Routine preventive retinal photography screenings: **no charge (not subject to the Deductible)**
- All other diagnostic procedures provided by Plan Providers who are not physicians (such as EKGs and EEGs): **a \$10 Copayment per encounter subject to the Deductible** except that certain diagnostic procedures are covered at **a \$250 Copayment per procedure subject to the Deductible** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
- Radiation therapy: **no charge subject to the Deductible**
- Ultraviolet light treatments: **no charge (not subject to the Deductible)**

Outpatient Prescription Drugs, Supplies, and Supplements

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

- Items prescribed by Plan Physicians in accord with our drug formulary guidelines
- Items prescribed by the following Non–Plan Providers unless a Plan Physician determines that the item is not Medically Necessary or the drug is for a sexual dysfunction disorder:
 - ◆ Dentists if the drug is for dental care

- ◆ Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) and the drug, supply, or supplement is covered as part of that referral
- ◆ Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described under "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)

How to obtain covered items

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

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

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

Outpatient drugs, supplies, and supplements

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

- Drugs for which a prescription is required by law. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary
- Diaphragms, cervical caps, contraceptive rings, contraceptive patches, and oral contraceptives (including emergency contraceptive pills)

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

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

- Generic items (other than those described below in this "Cost Sharing for outpatient drugs, supplies, and supplements" section) at a Plan Pharmacy: **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
- Generic items (other than those described below in this "Cost Sharing for outpatient drugs, supplies, and supplements" section) through our mail-order service: **a \$10 Copayment** for up to a 30-day supply or **a \$20 Copayment** for a 31- to 100-day supply
- Brand-name items and compounded products (other than those described below in this "Cost Sharing for outpatient drugs, supplies, and supplements" section) at a Plan Pharmacy: **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
- Brand-name items and compounded products (other than those described below in this "Cost Sharing for outpatient drugs, supplies, and supplements" section) through our mail-order service: **a \$35 Copayment** for up to a 30-day supply or **a \$70 Copayment** for a 31- to 100-day supply
- 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 *Membership Agreement and Evidence of Coverage* is amended to exclude a drug that we have been covering and providing to you under this *Membership Agreement and Evidence of Coverage*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration): **50% Coinsurance** for up to a 30-day supply in a 30-day period

- Diaphragms and cervical caps: **a \$35 Copayment per item**

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

Certain intravenous drugs, supplies, and supplements

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

Diabetes urine-testing supplies and insulin-administration devices

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

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

Day supply limit

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

The pharmacy may reduce the day supply dispensed at the Cost Sharing specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the

market or for specific drugs (your Plan Pharmacy can tell you if a drug you take is one of these drugs).

About our drug formulary

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

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

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

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

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

are receiving covered hospice care (refer to "Hospice Care")

Outpatient prescription drugs, supplies, and supplements exclusions

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

Prosthetic and Orthotic Devices

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

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

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

Internally implanted devices

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

External devices

We cover the following external prosthetic and orthotic devices at **no charge (not subject to the Deductible)**:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)

- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres required to hold a prosthesis every 12 months
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

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

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

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

Prosthetic and orthotic devices exclusions

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

Reconstructive Surgery

We cover the following reconstructive surgery Services:

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

You pay the following for covered reconstructive surgery Services:

- Outpatient consultations, exams, and treatment: **a \$30 Copayment per visit (not subject to the Deductible)**
- Outpatient surgery: **a \$250 Copayment per procedure subject to the Deductible** if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Any other outpatient surgery is covered at a **\$30 Copayment per procedure (not subject to the Deductible)**
- Hospital inpatient care (including room and board, drugs, and Plan Physician Services): **a \$500 Copayment per day subject to the Deductible**

Services not covered under this "Reconstructive Surgery" section

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

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

Reconstructive surgery exclusions

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

Services Associated with Clinical Trials

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

- You are diagnosed with cancer

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

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

Services associated with clinical trials exclusions

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

Skilled Nursing Facility Care

Inside your Home Region Service Area, we cover at a **\$50 Copayment per day subject to the Deductible** up to 60 days per benefit period (including any days we covered under any other evidence of coverage) of skilled inpatient Services in a Plan Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility,

receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

We cover the following Services:

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

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

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

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

Transplant Services

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

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

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made
- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding,

furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor

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

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

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

Services not covered under this "Transplant Services" section

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

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

Vision Services

We do not cover eyeglasses or contact lenses (except for special contact lenses described in this "Vision Services" section). However, we do cover the following:

- Routine vision screenings that are Preventive Care Services: **no charge (not subject to the Deductible)**
- Eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses: **a \$30 Copayment per visit (not subject to the Deductible)**

Special contact lenses for aniridia and aphakia. We cover the following special contact lenses at Plan

Medical Offices or Plan Optical Sales Offices when prescribed by a Plan Physician or Plan Optometrist:

- Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris): **no charge (not subject to the Deductible)**. We will not cover an aniridia contact lens if we provided an allowance toward (or otherwise covered) more than one aniridia contact lens for that eye within the previous 12 months (including when we provided an allowance toward, or otherwise covered, one or more aniridia contact lenses under any other evidence of coverage)
- Up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) per calendar year to treat aphakia (absence of the crystalline lens of the eye) for Members through age 9: **no charge (not subject to the Deductible)**. We will not cover an aphakic contact lens if we provided an allowance toward (or otherwise covered) more than six aphakic contact lenses for that eye during the same calendar year (including when we provided an allowance toward, or otherwise covered, one or more aphakic contact lenses under any other evidence of coverage)

Services not covered under this "Vision Services" section

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

- Services related to the eye or vision other than Services covered under this "Vision Services" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Cost Sharing" section)

Vision Services exclusions

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

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

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

Artificial insemination and conception by artificial means

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

Certain exams and Services

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

Chiropractic Services

Chiropractic Services and the Services of a chiropractor except as described in the "Chiropractic Services Amendment."

Cosmetic Services

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

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

Custodial care

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

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

Dental and orthodontic Services

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

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

Disposable supplies

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

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

Experimental or investigational Services

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

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

This exclusion does not apply to any of the following:

- Experimental or investigational Services when an investigational application has been filed with the federal Food and Drug Administration (FDA) and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by

research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol

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

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

Hair loss or growth treatment

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

Infertility Services

Services related to the diagnosis and treatment of infertility.

Intermediate care

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

Items and services that are not health care items and services

For example, we do not cover:

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

Items and services to correct refractive defects of the eye

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

Massage therapy

Oral nutrition

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

This exclusion does not apply to any of the following:

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

Residential care

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

Routine foot care items and services

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

Services not approved by the federal Food and Drug Administration

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

This exclusion does not apply to any of the following:

- Services covered under the "Emergency Services and Urgent Care" section that you receive outside the U.S.
- Experimental or investigational Services when an investigational application has been filed with the

FDA and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol

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

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

Services performed by unlicensed people

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

Services related to a noncovered Service

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

Surrogacy

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

Transgender surgery

Travel and lodging expenses

Travel and lodging expenses, except that in some situations if the Medical Group refers you to a Non-Plan Provider as described in "Medical Group authorization

procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines **not subject to the Deductible**. Our travel and lodging guidelines are available from our Member Service Call Center.

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

Limitations

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

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

Coordination of Benefits

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

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:

For Northern California Members:

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

For Southern California Members:

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

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

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

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

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

Medicare benefits

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

Surrogacy arrangements

If you enter into a surrogacy arrangement, you must pay us Charges for covered Services you receive related to conception, pregnancy, or delivery in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the compensation you are entitled to receive under the

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

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

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

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

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

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

U.S. Department of Veterans Affairs

For any Services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of

Veterans Affairs, and when we cover any such Services we may recover the value of the Services from the Department of Veterans Affairs.

Workers' compensation or employer's liability benefits

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

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

Dispute Resolution

Grievances

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

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

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

- We did not decide fully in your favor on a claim for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits and Cost Sharing" section and you want to appeal our decision
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility
- Health Plan has terminated your coverage and you believe your coverage has been terminated improperly
- We denied your membership application

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

- If we did not decide fully in your favor on a claim for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits and Cost Sharing" section and you want to appeal our decision, you can submit your grievance in one of the following ways:
 - ◆ to the Claims Department at the following address:
 - For Northern California Members:*
Kaiser Foundation Health Plan, Inc.
Special Services Unit
P.O. Box 23280
Oakland, CA 94623
 - For Southern California Members:*
Kaiser Foundation Health Plan, Inc.
Special Services Unit
P.O. Box 7136
Pasadena, CA 91109
 - ◆ by calling our Member Service Call Center at 1-800-464-4000 or 1-800-390-3510 (TTY users call 1-800-777-1370)
- For all other issues, you can submit your grievance in one of the following ways:
 - ◆ to the Member Services Department at a Plan Facility (please refer to *Your Guidebook* for addresses)
 - ◆ by calling our Member Service Call Center at 1-800-464-4000 (TTY users call 1-800-777-1370)
 - ◆ through our website at **kp.org**

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

Expedited grievance

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

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

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

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

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

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

Supporting Documents

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

Who May File

The following persons may file a grievance:

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

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

Department of Managed Health Care Complaints

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

Independent Medical Review (IMR)

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

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

- One of these situations applies to you:
 - ♦ you have a recommendation from a provider requesting Medically Necessary Services
 - ♦ you have received Emergency Services, emergency ambulance Services, or Urgent Care

from a provider who determined the Services to be Medically Necessary

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

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

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

Experimental or investigational denials

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

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

debilitating" means diseases or conditions that cause major irreversible morbidity

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

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

Binding Arbitration

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

Scope of arbitration

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

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

or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted

- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- The claim is *not* within the jurisdiction of the Small Claims Court
- If coverage under this *Membership Agreement and Evidence of Coverage* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), the claim is *not* about an "adverse benefit determination" as defined in that regulation. Note: Claims about "adverse benefit determinations" are excluded from this binding arbitration requirement only until such time as the regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice

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

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

"Kaiser Permanente Parties" include:

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

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

Initiating arbitration

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

Serving Demand for Arbitration

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

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

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

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

Filing fee

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

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the

Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling our Member Service Call Center.

Number of arbitrators

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

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

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

Payment of arbitrators' fees and expenses

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

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

Costs

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

Rules of Procedure

Arbitrations shall be conducted according to the Rules of Procedure developed by the Office of the Independent

Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from our Member Service Call Center.

General provisions

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

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

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

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

How You May Terminate Your Membership

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

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

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, 2012, your termination date is January 1, 2013, and your last minute of coverage is at 11:59 p.m. on December 31, 2012.

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 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 *Membership Agreement and Evidence of Coverage* ends. Your premiums may differ from those under this

Membership Agreement and Evidence of Coverage. 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

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

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

Termination for Nonpayment of Premiums

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

Your Premium payment for the upcoming coverage month is due on the first day of that month. If we do not receive full Premium payment on or before the first day of the coverage month, we will send a notice of nonreceipt of payment (a "Late Notice") to the

Subscriber's address of record. This Late Notice will include the following information:

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

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

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

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

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

Reinstatement after termination for nonpayment of Premiums

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

If we terminate this *Membership Agreement and Evidence of Coverage* for nonpayment of Premiums, we will permit reinstatement of this *Membership Agreement and Evidence of Coverage* three times during any 12-month period if we receive the amounts owed within 15

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

Termination for Discontinuance of a Product

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

Payments after Termination

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

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

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

State Review of Membership Termination

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

Miscellaneous Provisions

Administration of this *Membership Agreement and Evidence of Coverage*

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

Advance directives

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

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

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

Membership Agreement and Evidence of Coverage binding on Members

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

Applications and statements

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

Assignment

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

Attorney and advocate fees and expenses

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

Claims review authority

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

Governing law

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

Health Insurance Counseling and Advocacy Program (HICAP)

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

No waiver

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

Nondiscrimination

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

Notices

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

Other formats for Members with disabilities

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

Overpayment recovery

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

Privacy practices

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

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

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

Public policy participation

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

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

Telephone access (TTY)

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

Helpful Information

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

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

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

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

How to Reach Us

Appointments

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

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

Not sure what kind of care you need?

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

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

Member Services

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

- Call** **1-800-464-4000**
1-800-777-1370 (TTY)
Weekdays 7 a.m. to 7 p.m., and weekends 7 a.m. to 3 p.m. (except holidays)
- Write** Member Services Department at a Plan Facility (refer to *Your Guidebook* for addresses)
- Website** **kp.org**

If you have questions about a bill or about how much you have paid toward your Deductible or annual out-of-pocket maximum, or to get an estimate of Charges for Services that are subject to the Deductible, please call us:

- Call** **1-800-390-3507**
1-800-777-1370 (TTY)
Weekdays 7 a.m. to 5 p.m.

Authorization for Post-Stabilization Care

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

- Call** **1-800-225-8883** or the notification telephone number on your Kaiser Permanente ID card
711 (TTY)
24 hours a day, seven days a week

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

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

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

- Website** **kp.org**

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

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

- Write** *For Northern California Members:*
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 12923
Oakland, CA 94604-2923
- For Southern California Members:*
Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7004
Downey, CA 90242-7004

Payment Responsibility

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

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

Chiropractic Services Amendment

This document amends your Kaiser Foundation Health Plan, Inc. (Health Plan) *Evidence of Coverage* to add coverage for Chiropractic Services as described in this "Chiropractic Services Amendment." All provisions of the *Evidence of Coverage* apply to coverage described in this document except for the following sections:

- "How to Obtain Services" (except that the "Completion of Services from Non-Plan Providers," or for Kaiser Permanente Senior Advantage or

Medicare Cost Members, the "Termination of a Plan Provider's contract and completion of Services" section, does apply to coverage described in this document)

- "Plan Facilities"
- "Emergency Services and Urgent Care"
- "Benefits and Cost Sharing" (except that the "Annual out-of-pocket maximum" section does apply to coverage described in this document)

Kaiser Foundation Health Plan, Inc. contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to make the ASH Plans network of Participating Chiropractors available to you. When you need chiropractic care, you have direct access to more than 2,800 licensed chiropractors in California. You can obtain covered Services from any Participating Chiropractor without a referral from a Plan Physician. Cost Sharing is due when you receive covered Services.

Definitions

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

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

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

Emergency Chiropractic Services: Covered Chiropractic Services provided for the treatment of a sudden and unexpected onset of a Neuromusculoskeletal Disorder which manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate Chiropractic Services to result in serious jeopardy to your health or body functions or organs.

Neuromusculoskeletal Disorders: Conditions with associated signs and symptoms related to the nervous, muscular, or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders, or biomechanical dysfunction of the joints of the body or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial

structures), and related neurological manifestations or conditions.

Non-Participating Chiropractor: A chiropractor other than a Participating Chiropractor.

Non-Participating Provider: A provider other than a Participating Provider.

Participating Chiropractor: A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide Medically Necessary Chiropractic Services to you. A list of Participating Chiropractors is available on the ASH Plans website at ashplans.com or from the ASH Plans Member Services Department toll free at **1-800-678-9133** (TTY users call **711**). The list of Participating Chiropractors is subject to change at any time, without notice. If you have questions, please call the ASH Plans Member Services Department.

Participating Provider: A Participating Chiropractor or any licensed provider with which ASH Plans contracts to provide covered care, including laboratory tests or X-rays that are covered chiropractic care.

Treatment Plan: A proposed course of treatment for your Neuromusculoskeletal Disorder, which may include laboratory tests, X-rays, chiropractic appliances, and a specific number of visits for chiropractic manipulations, adjustments, and therapies that are Medically Necessary Chiropractic Services for you.

Participating Providers

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

ASH Plans contracts with Participating Chiropractors and other Participating Providers to provide covered Chiropractic Services (including laboratory tests, X-rays, and chiropractic appliances). You must receive Services covered under this "Chiropractic Services Amendment" from a Participating Provider, except for Emergency Chiropractic Services and Services that are not available from Participating Providers that are authorized in advance by ASH Plans.

How to obtain Services

To obtain Services covered under this "Chiropractic Services Amendment," call a Participating Chiropractor to schedule an initial examination. If additional Services are required, your Participating Chiropractor will prepare

a Treatment Plan. The ASH Plans Clinical Services Manager will authorize the Treatment Plan if the Services are covered and the Services are Medically Necessary Chiropractic Services for you. ASH Plans will disclose to you, upon request, the process that it uses to authorize a Treatment Plan. If you have questions or concerns, please contact ASH Plans or Kaiser Permanente as described under "Member Services" in this "Chiropractic Services Amendment."

Covered Services

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

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- ASH Plans has authorized the Services as part of your Treatment plan, except for:
 - ◆ the initial examination described under "Office Visits" in this "Covered Services" section
 - ◆ Emergency Chiropractic Services described under "Emergency chiropractic Services" in this "Covered Services" section
- You receive the Services from Participating Providers, except for:
 - ◆ Emergency Chiropractic Services described under "Emergency chiropractic Services" in this "Covered Services" section
 - ◆ Services that are not available from Participating Providers that are authorized in advance by ASH Plans

Covered Services are provided at the Cost Sharing listed in this "Covered Services" section. If you receive Services that are not covered under this "Combined Chiropractic and Acupuncture Services Amendment," you may be liable for the full price of those Services.

The Cost Sharing you pay for Services covered under this "Chiropractic Services Amendment" does not apply toward the annual out-of-pocket maximum described in your Health Plan *Evidence of Coverage*.

If you are a Kaiser Permanente Senior Advantage or Medicare Cost Member, please refer to your Health Plan *Evidence of Coverage* for information about the chiropractic Services that we cover in accord with

Medicare guidelines, which are separate from the Services covered under this "Combined Chiropractic and Acupuncture Services Amendment."

Office visits

We cover up to a combined total of 20 of the following types of office visits per calendar year at a

\$15 Copayment per visit:

- **Chiropractic office visits.** Each office visit counts toward the calendar year visit limit even if an adjustment is not provided during the visit:
 - ◆ **Initial examination:** An examination performed by a Participating Chiropractor to determine the nature of your problem (and, if appropriate, to prepare a Treatment Plan), and to provide Medically Necessary Chiropractic Services, which may include an adjustment and adjunctive therapy (such as ultrasound, hot packs, cold packs, or electrical muscle stimulation). We cover an initial examination only if you have not already received covered Services from a Participating Chiropractor in the same calendar year for your Neuromusculoskeletal Disorder
 - ◆ **Subsequent office visits:** Subsequent Participating Chiropractor office visits for Medically Necessary Chiropractic Services, which may include an adjustment, adjunctive therapy, and a re-examination to assess the need to continue, extend, or change a Treatment Plan

Laboratory tests and X-rays

We cover Medically Necessary laboratory tests and X-rays when prescribed as part of covered chiropractic care described under "Office visits" in this "Covered Services" section at **no charge** when a Participating Chiropractor provides the Services or refers you to a Participating Provider for the Services.

Chiropractic appliances

We provide a **\$50 Allowance per calendar year** toward the ASH Plans fee schedule price for chiropractic appliances listed in this paragraph when the item is prescribed and provided to you by a Participating Chiropractor as part of covered chiropractic care described under "Office visits" in this "Covered Services" section. If the price of the item(s) in the ASH Plans fee schedule exceeds \$50 (the Allowance), you will pay the amount in excess of \$50 (and that payment does not apply toward the annual out-of-pocket maximum described in your Health Plan *Evidence of Coverage*). Covered chiropractic appliances are limited to: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or

lumbar), ankle braces, knee braces, rib supports, and wrist braces.

Second opinions

If you request a second opinion, it will be provided to you by a Participating Chiropractor who is an appropriately qualified chiropractor (a chiropractor who is acting within his or her scope of practice and who possesses a clinical background related to the illness or condition associated with the request for a second opinion). To get a second opinion, make an appointment with a Participating Chiropractor. We cover office visits for a second opinion at a **\$15 Copayment per visit** and visits for a second opinion count toward your annual visit limit unless a Participating Chiropractor refers you to another Participating Chiropractor for a second opinion consultation that does not include treatment. If ASH Plans determines that there isn't a Participating Chiropractor who is an appropriately qualified chiropractor for your condition, ASH Plans will authorize a referral to a Non-Participating Chiropractor for a second opinion.

Emergency chiropractic Services

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

How to file a claim. As soon as possible after receiving Emergency Chiropractic Services, you must file an ASH Plans claim form. To request a claim form or for more information, please call ASH Plans toll free at **1-800-678-9133** (TTY users call **711**). You must send the completed claim form to:

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

Exclusions and Limitations

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this "Chiropractic Services Amendment" regardless of whether the services are within the scope of a provider's license or certificate:

- Any Services not provided by a Participating Chiropractor or Participating Provider, except for Emergency Chiropractic Services, and Services that are not available from Participating Providers but that are authorized in advance by ASH Plans
- Services for asthma or addiction, such as nicotine addiction
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational Services. If you are enrolled under a Health Plan *Evidence of Coverage* that does not require members to have Medicare, please refer to the "Dispute Resolution" section of that *Evidence of Coverage* for information about Independent Medical Review related to denied requests for experimental or investigational Services
- CT scans, MRIs, PET scans, bone scans, nuclear medicine, and any other type of diagnostic imaging or radiology other than X-rays covered under the "Covered Services" section of this "Chiropractic Services Amendment"
- Ambulance and other transportation
- Education programs, non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered under "Chiropractic appliances" in the "Covered Services" section of this "Chiropractic Services Amendment"
- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California, except for Emergency Chiropractic Services
- Hospital services, anesthesia, manipulation under anesthesia, and related services

- For chiropractic services, adjunctive therapy not associated with spinal, muscle, or joint manipulations
- Dietary and nutritional supplements, such as vitamins, minerals, herbs, herbal products, injectable supplements, and similar products
- Massage therapy
- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California
- Maintenance care (services provided to Members whose treatment records indicate that they have reached maximum therapeutic benefit)

Member Services

If you have a question or concern regarding the Services you received from a Participating Provider, you may call ASH Plans Member Services toll free at **1-800-678-9133** (TTY users call **711**) weekdays from 5 a.m. to 6 p.m., or write ASH Plans at:

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

Grievances

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about Services you received. If you are a Kaiser Permanente Senior Advantage or Medicare Cost Member, you may submit your grievance orally or in writing to Kaiser Permanente as described in the "Coverage Decisions, Appeals, and Complaints" section of your Health Plan *Evidence of Coverage*. Otherwise, you may submit your grievance orally or in writing to Kaiser Permanente as described in the "Dispute Resolution" section of your Health Plan *Evidence of Coverage*.