you give us proof of their incapacity and dependency within 60 days after we request it (see "Disabled dependent certification" below in this "Additional eligibility requirements" section)

Note: If you are a subscriber under Kaiser Permanente Senior Advantage or one of our other plans that requires members to have Medicare, all of your dependents who are enrolled under this or any other non-Medicare evidence of coverage offered by your Group must be enrolled under the same non-Medicare evidence of coverage. A "non-Medicare" evidence of coverage is one that does not require members to have Medicare.

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 within 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 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 of our request 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.

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

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

- If a Subscriber who has Medicare Part B retires and the Subscriber's Group has a Kaiser Permanente Senior Advantage plan for retirees, the Subscriber should enroll in the plan if eligible.

- If the Subscriber has dependents who have Medicare and your Group has a Kaiser Permanente Senior Advantage plan (or of one our other plans that require members to have Medicare), the Subscriber may be able to enroll them as dependents under that plan.

- If the Subscriber retires and your Group does not offer coverage to retirees, you may be eligible to continue membership as described in the "Continuation of Membership" section.

- If federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary, your coverage under this Evidence of Coverage will be the same as it would be if you had not become eligible for Medicare. However, you may also be eligible to enroll in Kaiser Permanente Senior Advantage through your Group if you have Medicare Part B.

- If you are (or become) eligible for Medicare and are in a class of beneficiaries for which your Group's health care coverage is secondary to Medicare, you should consider enrollment in Kaiser Permanente Senior Advantage through your Group if you are eligible.

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

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

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

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

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

When You Can Enroll and When Coverage Begins

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

If you are eligible to be a Dependent under this Evidence of Coverage but the subscriber in your family is enrolled under a Kaiser Permanente Senior Advantage evidence of coverage offered by your Group (or an evidence of coverage for one of our other plans that your Group offers that requires members to have Medicare), the rules for enrollment of Dependents in this "When You Can Enroll and When Coverage Begins" section apply, not the rules for enrollment of dependents in the subscriber's evidence of coverage.

New employees

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

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

Adding new Dependents to an existing account

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

Effective date of coverage. The effective date of coverage for newly acquired Dependents 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 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

- For all other newly acquired Dependents, the effective date of coverage is determined by your Group

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

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

- You become eligible as described in this "Special enrollment" section

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

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

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

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

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

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

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

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

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

Special enrollment due to eligibility for premium
assistance. You may enroll as a Subscriber (along with
eligible Dependents), and existing Subscribers may add
eligible Dependents, if you or a dependent become
eligible for premium assistance through the Medi-Cal
program. Premium assistance is when the Medi-Cal
program pays all or part of premiums for employer group
coverage for a Medi-Cal beneficiary. To request
enrollment in your Group’s health care coverage, the
Subscriber must submit a Health Plan-approved
enrollment or change of enrollment application to your
Group within 60 days after you or a dependent become
eligible for premium assistance. Please contact the
California Department of Health Care Services to find
out if premium assistance is available and the eligibility
requirements.

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

How to Obtain Services

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

• Authorized referrals as described under “Getting a
  Referral” in this “How to Obtain Services” section

• Emergency ambulance Services as described under
  “Ambulance Services” in the “Benefits and Cost
  Sharing” section

• Emergency 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

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 that protect against disease,
  promote health, or detect disease at its earliest stages
  before noticeable symptoms develop)

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

- **Transplants.** If your Plan Physician makes a written referral for a transplant, the Medical Group’s regional transplant advisory committee or board (if one exists) will authorize the Services if it determines that they are Medically Necessary. In cases where no transplant committee or board exists, the Medical Group will refer you to the 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.

**Completion of Services from Non–Plan Providers**

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

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

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

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends.

- We may cover Services for serious chronic conditions until the earlier of (1) 12 months from your effective date of coverage if you are a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
♦ It persists without full cure
♦ It worsens over an extended period of time
♦ It requires ongoing treatment to maintain remission or prevent deterioration

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

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

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

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

Second Opinions

If you request a second opinion, it will be provided to you when Medically Necessary by an appropriately qualified medical professional. This is a physician who is acting within his or her scope of practice and who possesses a clinical background related to the illness or condition associated with the request for a second medical opinion. Here are some examples of when a second opinion is Medically Necessary:
♦ Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or necessary
♦ You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
♦ The clinical indications are not clear or are complex and confusing
♦ A diagnosis is in doubt due to conflicting test results
♦ The Plan Physician is unable to diagnose the condition
♦ The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
♦ You have concerns about the diagnosis or plan of care

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

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

How Plan Providers are paid

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

Financial liability

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

Termination of a Plan Provider’s contract

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

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

Visiting Other Regions

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

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

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

Your ID Card

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

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

Getting Assistance

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

Member Services

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Call Center representatives are available to assist you weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays) toll free at 1-800-464-4000 or 1-800-777-1370 (TTY for the deaf, hard of hearing, or speech impaired). For your convenience, you can also contact us through our 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 to get an estimate of Charges for Services that are subject to the Deductible, please call our Member Service Call Center weekdays from 8 a.m. to 7 p.m. toll free at 1-800-390-3507. 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 our Service Area. Please refer to *Your Guidebook* for the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. Additional Plan Medical Offices are listed in *Your Guidebook* and on our website at kp.org. This list is subject to change at any time without notice. If there is a change to this list of Plan Facilities, we will update this list in any Plan evidence of coverage issued after that date. If you have any questions about the current locations of Plan Facilities, please call our Member Service Call Center.

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

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

**Campbell**
- Medical Offices: 220 E. Hacienda Ave.

**Clovis**
- Medical Offices: 2071 Herndon Ave.

**Daly City**
- Medical Offices: 395 Hickey Blvd.

**Davis**
- Medical Offices: 1955 Cowell Blvd.

**Elk Grove**
- Medical Offices: 9201 Big Horn Blvd.

**Fairfield**
- Medical Offices: 1550 Gateway Blvd.

**Folsom**
- Medical Offices: 2155 Iron Point Rd.

**Fremont**
- Hospital and Medical Offices: 39400 Paseo Padre Pkwy.

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

**Gilroy**
- Medical Offices: 7520 Arroyo Circle

**Hayward**
- Hospital and Medical Offices: 27400 Hesperian Blvd.

**Lincoln**
- Medical Offices: 1900 Dresden Dr.

**Livermore**
- Medical Offices: 3000 Las Positas Rd.
Manteca
- Hospital and Medical Offices: 1777 W. Yosemite Ave.
- Medical Offices: 1721 W. Yosemite Ave.

Martinez
- Medical Offices: 200 Muir Rd.

Milpitas
- Medical Offices: 770 E. Calaveras Blvd.

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

Mountain View
- Medical Offices: 555 Castro St.

Napa
- Medical Offices: 3285 Claremont Way

Novato
- Medical Offices: 97 San Marin Dr.

Oakhurst
- Medical Offices: 40595 Westlake Dr.

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

Petaluma
- Medical Offices: 3900 Lakeville Hwy.

Pinole
- Medical Offices: 1301 Pinole Valley Rd.

Pleasanton
- Medical Offices: 7601 Stoneridge Dr.

Rancho Cordova
- Medical Offices: 10725 International Dr.

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

Richmond
- Hospital and Medical Offices: 901 Nevin Ave.

Rohnert Park
- Medical Offices: 5900 State Farm Dr.

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

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

San Bruno
- Medical Offices: 901 El Camino Real

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

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

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

Santa Clara
- Hospital and Medical Offices: 700 Lawrence Expwy.

Santa Rosa
- Hospital and Medical Offices: 401 Bicentennial Way

Selma
- Medical Offices: 2651 Highland Ave.

South San Francisco
- Hospital and Medical Offices: 1200 El Camino Real

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

Tracy
- Medical Offices: 2185 W. Grant Line Rd.

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

Union City
- Medical Offices: 3553 Whipple Rd.

Vacaville
- Hospital and Medical Offices: 1 Quality Dr.

Vallejo
- Hospital and Medical Offices: 975 Sereno Dr.

Walnut Creek
- Hospital and Medical Offices: 1425 S. Main St.
- Medical Offices: 320 Lennon Ln.
Note: State law requires evidence of coverage documents to include the following notice: "Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the Kaiser Permanente Member Service Call Center, to ensure that you can obtain the health care services that you need."

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

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

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

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

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 and exams

- The Cost Sharing for other covered Urgent Care is the Cost Sharing that you would pay if the Services were not Urgent Care. For example, if the Urgent Care 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 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.

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

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

We will respond to your claim as follows:

- If coverage under this *Evidence of Coverage* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), we will send our written decision within 30 calendar days after we receive the claim unless we request additional information from you or the Non-Plan Provider. If we request additional information, we will send our written decision no later than 15 calendar days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in the letter, we will make our decision based on the information we have.

- If coverage under this *Evidence of Coverage* is not subject to the ERISA claims procedure regulation, we will send our written decision within 45 business days after we receive the claim unless we request additional information from you or the Non-Plan Provider. If we request additional information, we will send our written decision no later than 45 business days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in the letter, we will make our decision based on the information we have.

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

**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:
  - 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 our Service Area, except where specifically noted to the contrary in the sections listed below for the following Services:
  • authorized referrals as described under “Getting a Referral” in the “How to Obtain Services” section
  • emergency ambulance Services as described under “Ambulance Services” in this “Benefits and Cost Sharing” section
  • Emergency 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 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

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

• If you are receiving covered inpatient hospital or Skilled Nursing Facility Services on the effective date of this Evidence of Coverage, you pay the Cost Sharing in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Sharing in effect on the date you receive the Services

• For items ordered in advance, you pay the Cost Sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription

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

• If you receive more than one Service from a provider, or Services from more than one provider, you may be required to pay separate Cost Sharing amounts for each Service and each provider. For example, if you receive both preventive Services and non-preventive Services in the same visit, you may have to pay separate Cost Sharing for each Service received during that visit. Similarly, if your physician requests the assistance of another provider during a procedure, you may have to pay separate Cost Sharing amounts for the Services provided by each provider. If you have questions about Cost Sharing, please contact our Member Service Call Center

• In some cases, we may agree to bill you for your Cost Sharing amounts

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

Deductibles

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

• $1,000 per calendar year for self-only enrollment (a Family of one Member)

• $1,000 per calendar year for any one Member in a Family of two or more Members

• $2,000 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 $1,000 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 $2,000 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. All covered Services are subject to the Deductible, except for those covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section and those that are not subject to the Deductible in this "Benefits and Cost Sharing" section. Only the following payments count toward this Deductible:

- Payments you make for covered Services that are subject to this Deductible under this Evidence of Coverage

- When your Group enrolls for the first time, we will apply toward this Deductible certain payments you made toward a deductible under your prior coverage with the same group if all of the following are true:
  - you received the Services within 90 days before September 1, 2011
  - the Services would have been covered and subject to this Deductible under this Evidence of Coverage if a Plan Provider had provided them during the term of this Evidence of Coverage

When Services are subject to a Deductible and you have not met the Deductible, you must pay Charges for the Services you are scheduled to receive when you check in for an appointment or procedure. 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 go to our website at kaiserpermanente.com or call our Member Service Call Center toll free at 1-800-390-3507. Note: If you pay a Deductible amount for a Service that has a visit limit, the Services count toward reaching the limit.

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

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

Drug deductible. The Deductible that applies to certain drugs, supplies, and supplements is not described in this "Deductibles" section (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section).

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 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:

- $3,000 per calendar year for self-only enrollment (a Family of one Member)
- $6,000 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 $3,000 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 $6,000 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 except amounts you paid under your prior coverage. Also, the Copayments and Coinsurance you pay for the following Services apply toward the annual out-of-pocket maximum except that Copayments and Coinsurance you pay for Services covered under "Infertility Services" in this "Benefits and Cost Sharing" section do not apply to the annual out-of-pocket maximum:

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

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. We will also send you a statement summarizing the amounts you have paid toward your annual out-of-pocket maximum. You can also obtain a copy of this statement from our Member Service Call Center toll free at 1-800-390-3507.

Preventive Care Services

We cover a variety of preventive care Services, which are 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

This "Preventive Care Services" section explains Cost Sharing for some preventive care Services, but 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 a preventive care Service that is an outpatient laboratory Service only if it is covered as described under the "Outpatient Imaging, Laboratory, and Special Procedures" section, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

We cover at no charge (not subject to the Deductible) the preventive care Services on the health care reform preventive care Services list for Members enrolled in our California Regions. This list is subject to change at any time and is available on our website at kp.org/prevention or by calling our Member Service Call Center. If you receive any other covered Services during a preventive care visit, you will pay the applicable Cost Sharing for those Services.

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

- Eye exams for refraction and preventive vision screenings
- Family planning counseling and programs
- Flexible sigmoidoscopies and colonoscopies
- Health education counseling and programs
- Hearing exams and screenings
- Immunizations (including vaccines) 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

If you receive both preventive and non-preventive Services in the same visit, you may have to pay separate Cost Sharing amounts for each Service received during that visit. For example, if you go in for a preventive exam, and your physician diagnoses you with an infection, you may have to pay separate Cost Sharing amounts for both the preventive exam and for the Services performed to diagnose a condition.

**Outpatient Care**

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

• Most primary and specialty care consultations and exams: a $30 Copayment per visit (not subject to the Deductible)

• Routine physical maintenance exams, including well-woman exams: no charge (not subject to the Deductible)

• Well-child preventive exams for Members through age 23 months: no charge (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: no charge (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: no charge (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 vaccines) administered to you in a Plan Medical Office: no charge (not subject to the Deductible)

• Flexible sigmoidoscopies: no charge (not subject to the Deductible)

• Screening colonoscopies: no charge (not subject to the Deductible)

• Allergy injections (including allergy serum): no charge subject to the Deductible

• Outpatient surgery: 30% Coinsurance 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): 30% Coinsurance 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: 30% Coinsurance 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 and exams: a $30 Copayment per visit (not subject to the Deductible)

• Emergency Department visits: 30% Coinsurance subject to the Deductible

• House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician: no charge (not subject to the Deductible)
• 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 and exams 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
• Infertility Services
• Mental Health Services
• Ostomy and Urological Supplies
• Outpatient Imaging, Laboratory, and Special Procedures
• Outpatient Prescription Drugs, Supplies, and Supplements
• Prosthetic and Orthotic Devices
• Reconstructive Surgery
• Services Associated with Clinical Trials
• Transplant Services
• Vision Services

Hospital Inpatient Care

We cover the following inpatient Services at 30% Coinsurance subject to the Deductible in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals inside our Service Area:

• Room and board, including a private room if Medically Necessary
• Specialized care and critical care units
• General and special nursing care
• Operating and recovery rooms
• Services of Plan Physicians, including consultation and treatment by specialists
• Anesthesia
• Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, please refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section)
• Radioactive materials used for therapeutic purposes
• Durable medical equipment and medical supplies
• Imaging, laboratory, and special procedures, including MRI, CT, and PRT 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
• Infertility Services
• Mental Health Services
• Prosthetic and Orthotic Devices
• Reconstructive Surgery
• Services Associated with Clinical Trials
• Skilled Nursing Facility Care
• Transplant Services

Ambulance Services

Emergency
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) if one of the following is true:

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

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

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

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

**Services not covered under this "Bariatric Surgery" section**
Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

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

**Chemical Dependency Services**

**Inpatient detoxification**
We cover hospitalization at 30% Coinsurance 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 counseling and treatment: a $30 Copayment per visit (not subject to the Deductible)
- Group chemical dependency counseling and 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 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. 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 at a $30 Copayment per visit (not subject to the Deductible) if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

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

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

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

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

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)

You pay the following for these dental and orthodontic Services for cleft palate:

- Consultations and exams: a $30 Copayment per visit (not subject to the Deductible)

- Hospital inpatient care: 30% Coinsurance subject to the Deductible

- Outpatient surgery: 30% Coinsurance 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): 30% Coinsurance 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 our Service Area

- You satisfy all medical criteria developed by the Medical Group and by the facility providing the dialysis

- A Plan Physician provides a written referral for care at the facility

After 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 our 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: 30% Coinsurance subject to the Deductible

- One routine office consultation or exam per month with the multidisciplinary nephrology team: no charge (not subject to the Deductible)

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

Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered durable medical equipment (including repair or replacement of covered equipment, unless due to loss or misuse) is provided at 20% Co-insurance (not subject to the Deductible) except that external sexual dysfunction devices are provided at 50% Co-insurance (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.

Durable medical equipment for diabetes

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

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

Outside the Service Area

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

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

About our durable medical equipment formulary

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

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

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

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

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

**Durable medical equipment for home use exclusions**

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

**Health Education**

We cover a variety of 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 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 when the visit is solely for health education: no charge (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 cover the following:

- Routine preventive hearing screenings: no charge (not subject to the Deductible)
- Hearing exams to determine the need for hearing correction: no charge (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 (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 our Service Area

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

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

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

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

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

Home health care exclusions

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

Hospice Care

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

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

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside our Service Area or inside California but within 15 miles or 30 minutes from our Service Area (including a friend's or relative's home 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 care management of nursing needs
treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers

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

Infertility Services exclusions

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

Mental Health Services

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

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

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

- "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.
- A "Serious Emotional Disturbance" of a child under age 18 means mental disorders as identified in the 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 the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either (1) the child is at risk of removal from the home or has already been removed from the home, or (2) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
  - the child displays psychotic features, or risk of suicide or violence due to a mental disorder
  - the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 2 of the California Government Code