

Kaiser Permanente Health Plan
Contract Printing Instruction Sheet

Contract :232239-1.10

Group Size : L

Contract Type: HPREN

Document Release Type: FULL

Date : 12/04/2020

Region: SCR

PURCHASER	1	DIANE SWEENEY ASST DIR, BEN & COMP UNIVERSITY OF SAN FRANCISCO
12/04/2020		2130 FULTON ST SAN FRANCISCO, CA 94117-1080
CONSULTANT	1	DARREN V BAKER ALLIANT INSURANCE SERVICES, INC.
12/04/2020		2121 N CALIFORNIA BLVD STE 1000 WALNUT CREEK, CA 94596-7309
RECIPIENT	1	DIANE NELSON ASSISTANT VP, HR UNIVERSITY OF SAN FRANCISCO
12/04/2020		2130 FULTON ST SAN FRANCISCO, CA 94117-1080



December 3, 2020

DIANE SWEENEY, ASST DIR, BEN & COMP
UNIVERSITY OF SAN FRANCISCO
2130 FULTON ST
SAN FRANCISCO, CA 94117-1080

Re: New *Group Agreement* for Group ID # 232239
Renewal effective date: 01/01/2021

Dear DIANE SWEENEY,

We value being your health care partner, and look forward to continuing to work with you to provide your subscribers with quality care well into the future.

Enclosed, please find the new *Group Agreement* between UNIVERSITY OF SAN FRANCISCO and Kaiser Foundation Health Plan, Inc., Southern California Region, for the contract period January 1, 2021, through December 31, 2021. For a summary of the most important changes, see the enclosed 2021 *Renewal Notice: Group Agreement Changes and Clarifications*. Review these documents carefully and keep the *Group Agreement* for your records. Also, be sure to sign and mail the enclosed *Agreement Signature Page* to us as described on the *Signature Page* document.

If your group doesn't want to renew the *Group Agreement*, you'll need to give us advance written notice, as described under "Termination on Notice" in the "Termination of Agreement" section of your *Group Agreement*.

You should have already received the *Disclosure Form* and a *Summary of Benefits and Coverage*. These documents include information to help your employees make the right plan choice for their needs.

Please note: We require subscribers to agree to the use of binding arbitration to settle disputes when they enroll. In turn, your group must show that each subscriber has agreed. We have tools that can help. For details, see the *Administrative Handbook* on our website at account.kp.org. Kaiser Permanente's arbitration agreement with members is described in the *EOC*.

If you have any questions or need enrollment or enrollee materials for your subscribers, please contact your Kaiser Permanente account manager, Tamisha Apodaca, at 415-833-0522.

If you receive the *Group Agreement* or enrollment materials in electronic form, you are not authorized to modify or alter in any way the text or the formatting of these documents. If you post the electronic documents on your intranet site, you must do so in such a way so as to permit your subscribers to download and print a complete and accurate copy of the materials. Please refer to the *Group Agreement* for details about these requirements.

Thank you for continuing to offer Kaiser Permanente to your subscribers.

Sincerely,

A handwritten signature in black ink, appearing to read "W. Overgaard".

Wade J. Overgaard
Senior Vice President, Health Plan Operations

cc:

DARREN V BAKER
DIANE NELSON

Agreement Signature Page

Acceptance of Agreement

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

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

Binding Arbitration

As more fully set forth in the arbitration provision in the applicable *Evidence of Coverage*, disputes between Members, their heirs, relatives, or associated parties (on the one hand) and Health Plan, Kaiser Permanente health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising out of or related to this *Agreement*, including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this *Agreement*, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Members enrolled under this *Agreement* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the applicable *Evidence of Coverage* except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

Signatures

UNIVERSITY OF SAN FRANCISCO

Kaiser Foundation Health Plan, Inc.
Southern California Region



Authorized Group officer signature

Wade J. Overgaard
Authorized officer
Senior Vice President, Health Plan Operations

Please print your name and title

Executed in San Diego, CA effective 1/1/21

Date: 12/3/20

Date signed

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

Helpful information about disclosures that Group must make

The Group is required to provide certain disclosures about its group health plan to employees and dependents:

- As described in your *Group Agreement*, Group must notify subscribers and dependents about changes to coverage and provide an *Evidence of Coverage (EOC)*.
- If Group's group health plan is subject to Affordable Care Act (ACA) mandates, Group must provide any required ACA notices.
- If Group's group health plan is subject to ERISA, Group's plan administrator must provide a Summary Plan Description. In addition, Groups may have additional reporting and disclosure obligations under ERISA. These additional requirements are the Group's responsibility. For more information on your group health plan's obligations under ERISA, we recommend that you seek the advice of your own legal counsel. You may also find general information at <https://www.dol.gov/agencies/ebsa>. A handy Reporting and Disclosure Guide for Employee Benefit Plans is also available on that website.

In addition, the *EOCs* that are part of your *Group Agreement* provide certain notices as described in this document. The information in this document applies to commercial group coverage offered by Health Plan in its Northern and Southern California Regions (it does not apply to Medicare coverage, the Federal Employees Health Benefit Plan, or self-funded coverage). This document is not legal advice. Group should consult its own legal counsel for specific guidance related to its group health plan requirements.

Disclosures required by the ACA

The *EOCs* include the following notices required by the ACA:

- **Grandfathered status:** In *EOCs* for grandfathered coverage, a notice of grandfathered status in the "Benefit Highlights" section is provided.
- **Choice of provider.** A notice about designating a Plan Primary Care Physician (including a pediatrician for a child) is provided under "Your Personal Plan Physician" in the "How to Obtain Care" section.
- **Access to Plan obstetricians and gynecologists.** A notice that prior authorization is not required to receive care from obstetricians and gynecologists is provided under "Getting a Referral" in the "How to Obtain Care" section.
- **Claims procedure.** The procedure for post-service claims is explained in the "Post-Service Claims and Appeals" section. The procedure for all other requests for payment and services is explained in the "Dispute Resolution" section. The "Dispute Resolution" section says that binding arbitration is not required when governing law prevents the use of binding arbitration.
- **Nondiscrimination.** A nondiscrimination notice and language assistance taglines is provided.

SPD Disclosures required by ERISA

The Employee Retirement Income Security Act (ERISA) is a federal law that sets minimum standards for employee welfare benefit plans, which includes group health plans, and is established by private employers and employee organizations (e.g., unions). The plan administrator of an employee welfare benefit plan is responsible for development and distribution of a *Summary Plan Description (SPD)* to plan participants and beneficiaries. The plan administrator is an employee or designee of the employer or union plan sponsor. Health Plan underwrites group coverage that plan sponsors make available, but Health Plan is neither the "ERISA plan" nor the "plan administrator" of the group health plan.

The plan administrator of a group health plan may satisfy the Group's ERISA disclosure obligations by incorporating the *EOC* into the Group's *SPD* by reference. However, the *EOC* by itself does not satisfy the disclosure requirements under ERISA. If a disclosure required under ERISA is not in the *EOC*, or if the plan administrator chooses to not incorporate the *EOC* in the *SPD*, the plan administrator must provide the disclosure in the Group's *SPD*. If there are discrepancies between the description of Kaiser Permanente HMO-covered group health plan benefits appearing in the Group's *SPD* and those reflected in the *EOC*, the benefit description appearing in Kaiser Permanente's *EOC* will control.

The chart below identifies certain key ERISA disclosure requirements and whether those disclosures are in the *EOC*. It is intended for use as a reference tool, however, it is the plan administrator's responsibility to verify that the Group's *SPD*

satisfies all ERISA disclosure requirements. For more information about ERISA, visit the Department of Labor website at <https://www.dol.gov/agencies/ebsa>.

SPD Disclosure Requirement	Evidence of Coverage (EOC)
Eligibility	The <i>EOC</i> does not explain in detail Group’s eligibility requirements (there is only a summary of Health Plan eligibility requirements that appear in the “Premiums, Eligibility, and Enrollment” section). The plan administrator must include Group’s specific eligibility information in the Group’s <i>SPD</i> .
Special enrollment, including: <ul style="list-style-type: none"> • Special enrollment due to new dependents • Special enrollment due to loss of other coverage • Special enrollment due to eligibility for premium assistance • Special enrollment due to court or administrative order • Special enrollment due to reemployment after military service • Other special enrollment events 	<p>The <i>EOC</i> explains special enrollment rights in “Special enrollment” under “When You Can Enroll and When Coverage Begins” in the “Premiums, Eligibility and Enrollment” section. The plan administrator is required to document that plan participants and beneficiaries have been informed of these rights.</p> <p>The <i>EOC</i> does not describe the procedures governing qualified medical child support order (QMCSO) determinations or state that plan participants and beneficiaries can obtain, without charge, a copy of those procedures from the plan administrator. The plan administrator should include this information in the Group’s <i>SPD</i>.</p>
Michelle’s law (student status and eligibility)	Michelle’s law establishes that dependent children who are under the dependent child age limit of the group health plan eligibility rules meet the eligibility age requirement whether or not they are attending school. Therefore, Health Plan provides a notice about student leaves of absence only in <i>EOCs</i> where the dependent child age limit is higher for a student than the non-student. If the student age limit is higher, the notice appears in the “Who Is Eligible” section under “Additional eligibility requirements.”
Description of coverage, including: <ul style="list-style-type: none"> • Cost sharing • Exclusions and limitations • Prior authorization requirements • Provider network • Claims procedure 	<p>Under ERISA, a Group’s <i>SPD</i> may provide only a general description of plan benefits as long as the <i>SPD</i> references a detailed schedule of benefits and incorporates it by reference. That detailed schedule of benefits can be the Health Plan <i>EOC</i>, which offers a clear description of the benefits and the rules for obtaining those benefits. If the plan administrator chooses to incorporate the <i>EOC</i> by reference into the Group’s <i>SPD</i>, the Group may satisfy the ERISA coverage disclosure requirements by including the following text <i>without changes</i> as the introduction to the benefit chart in the Group’s <i>SPD</i>:</p> <ul style="list-style-type: none"> • “This benefit chart provides summary information only. It does not fully describe your benefit coverage. For details on your benefit coverage, please refer to your Kaiser Foundation Health Plan, Inc. (Health Plan) <i>Evidence of Coverage</i>. The Health Plan <i>Evidence of Coverage</i> is the binding document between Health Plan and its members. • As a condition of coverage, a Health Plan physician must determine that any requested services and items are medically necessary to prevent, diagnose, or treat a medical condition. Generally, requested services and items must be provided, prescribed, authorized, or directed by a Health Plan provider. Except as otherwise noted in the Health Plan <i>Evidence of Coverage</i>, you must receive the requested services and items from a Health Plan-designated provider inside the Health Plan Service Area in which you are enrolled. • For details on the benefit and claims review and adjudication procedures, please refer to the Health Plan <i>Evidence of Coverage</i>.”
Newborns’ and Mothers’ Health Protection Act (Newborn Act)	Health Plan covers hospital lengths of stay following childbirth for mothers and newborns in accord with the Newborn Act. To assist the plan administrator in complying with the ERISA notice requirement, a Newborn Act notice is included under “ERISA notices” in the “Miscellaneous Provisions” section of the <i>EOC</i> .

SPD Disclosure Requirement	Evidence of Coverage (EOC)
Women’s Health and Cancer Rights Act (WHCRA)	Health Plan covers mastectomy and reconstructive surgery and related services as required by WHCRA. To assist the plan administrator in complying with the ERISA notice requirement, a WHCRA notice is included under “ERISA notices” in the “Miscellaneous Provisions” section of the EOC.
ERISA rights	The <i>EOC</i> does not include a statement of ERISA rights. The plan administrator should include this information in the Group’s <i>SPD</i> .
COBRA	The <i>EOC</i> states that continuation health care coverage under federal COBRA or under state continuation coverage laws may be available following termination of group health coverage. If your employee benefit plan offers COBRA continuation coverage, your plan administrator is responsible for administration of this coverage (for example, your plan administrator is responsible for providing all notices related to continuation coverage, eligibility, and participation).
<p>Information about the employee benefit plan and how it is administered, such as:</p> <ul style="list-style-type: none"> • Name of the plan • Name and address of the entity maintaining the plan • Employer identification number, plan number, type of plan, and how it is administered • The plan administrator’s authority to terminate the plan or amend benefits, circumstances that may trigger ineligibility, denial, or reduction of benefits, and rights upon termination of plan or amendment of benefits 	Health Plan does not collect this information from groups and cannot include it in the <i>EOC</i> . The plan administrator must include this information in the Group’s <i>SPD</i> .

2021 Group Agreement Summary of Changes and Clarifications Notice Effective January 1, 2021, through December 31, 2021

Kaiser Foundation Health Plan, Inc., Southern California Region (“Health Plan”) is renewing your Group’s *Group Agreement* (“*Agreement*”), including the *Evidence of Coverage* (“*EOC*”) documents, effective January 1, 2021 (your Group’s “Anniversary Date”) by sending UNIVERSITY OF SAN FRANCISCO (“Group”) this “*Group Agreement Summary of Changes and Clarifications Notice*” (“*Notice*”) in accord with the “Term of Agreement and Renewal” section of your *Agreement*. This *Notice* includes a summary of the changes and clarifications that will be effective when your *Agreement* is renewed on January 1, 2021 (“*2021 Agreement*”) unless a different effective date is stated. Unless otherwise indicated, the changes and clarifications described here apply to each type of coverage that will be effective upon renewal of your *Agreement*. If you have not already received a *2021 Agreement*, please contact your broker or Health Plan account manager to obtain a copy. If your Group does not wish to renew your *Agreement*, your Group must give us advance written notice in accord with “Termination on Notice” in the “Termination of Agreement” section of your *Agreement*.

In certain circumstances, this summary may also include changes that we made to your *Agreement* during the 2020 plan year through an amendment. This summary does not include minor changes and clarifications that Health Plan is making to improve the readability of the *Agreement* or any changes we are making at your Group’s request.

The “Calculating Premiums” section of this *Notice* includes the Premiums that will be applicable to your *Agreement* upon renewal.

Note: Some capitalized terms in this *Notice* have special meaning. Please see the “Definitions” section of the applicable *EOC* document in your *Agreement* for terms you should know. In this *Notice* “Medicare *EOCs*” means Kaiser Permanente Senior Advantage *EOCs*, and “non-Medicare *EOCs*” means all *EOCs* other than Senior Advantage *EOCs*.

2021 Agreement

If you have not already received your *2021 Agreement* and your Group wants to make changes, please request them before your Anniversary Date. You will then receive your *2021 Agreement* shortly after you tell your Health Plan account manager about changes your Group wants to make. If you don’t wish to make changes, you don’t need to do anything to renew your *Agreement*. We will provide your Group with its *2021 Agreement* within 60 days after your Anniversary Date. If you would like to receive it sooner, please contact your Health Plan account manager.

We will provide the *2021 Agreement* to your Group online unless you have asked us to mail your Group a printed *2021 Agreement*. When we provide the *2021 Agreement* online, we will mail your Group a notice to let you know when the *2021 Agreement* is available to view and download.

Please keep in mind that unless your Group notifies us to make changes, your *2021 Agreement*, including the *EOC* documents, will reflect the same benefits and Cost Share information as your current *Agreement*, subject to the changes described in this *Notice*.

Global Changes to the Group Agreement, including EOC documents

Acupuncture for Chronic Low Back Pain

In Medicare EOCs, we have added the following acupuncture for chronic low back pain covered by Medicare:

- Acupuncture for chronic low back pain up to 12 visits in 90 days, in accord with Medicare guidelines. Chronic low back pain is defined as follows:
 - ◆ lasting 12 weeks or longer
 - ◆ non-specific, in that it has no identifiable systemic cause (i.e. not associated with metastatic, inflammatory, infectious, etc. disease)
 - ◆ not associated with surgery or pregnancy

- An additional eight sessions are covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.

Behavioral Health Treatment for Pervasive Developmental Disorder or Autism

We have removed the “Behavioral Health Treatment for Pervasive Developmental Disorder or Autism” section and related language in Medicare EOCs because these Services are now covered under Medicare Part B.

Durable Medical Equipment

Please note that effective January 1, 2021, the following changes to the “Durable Medical Equipment (“DME”) for home use” benefit will apply:

- *In non-Medicare EOCs, peak flow meters, and blood glucose monitors and their associated testing supplies will no longer be subject to any Plan Deductible in nongrandfathered plans. **This is pursuant to IRS Notice 19-45, which allows, but does not require, health plans to provide additional items and services outside of a deductible to individuals diagnosed with specified chronic conditions.** Peak flow meters are now listed as a separate line item in the “Durable Medical Equipment (“DME”) for home use” cost share table in the “Cost Share Summary” section of all EOCs. Previously, peak flow meters were categorized under “Other Base DME.”*
- *In Medicare EOCs, peak flow meters will now be listed under “Other covered DME items” at **no charge**. Previously, peak flow meters were categorized under “Base DME items” and covered at either no charge or 20% Coinsurance*

High Deductible Health Plan (HDHP) HMO Deductible Amount

For HDHP HMO plans, the Plan Deductible amount is subject to increase if the U.S. Department of the Treasury changes the minimum deductible required in HDHP HMO plans.

Home-delivered Meals

In Medicare EOCs, we have added coverage for meal delivery service under “Meals” in the “Benefits and Your Cost Share” section.

Lab Tests

Effective January 1, 2021, the following lab tests: A1c, LDL, INR for persons with liver disease or certain blood disorders, and glucose quantitative blood tests, will be covered at no charge (not applicable to any deductible) in all Medicare EOCs.

Maternal Mental Health Conditions (AB 577)

Effective January 1, 2020, the following conditions may make a Member eligible for completion of services from non-Plan providers, in accordance with state law:

- *Mental health conditions in pregnant Members that occur, or can impact the Member, during pregnancy or during the postpartum period including, but not limited to, postpartum depression. We may cover completion of these Services for up to 12 months from the mental health diagnosis or from the end of pregnancy, whichever occurs later*

Completion of services is described under “Completion of Services from Non-Plan Providers” in the “Getting a Referral” section of non-Medicare EOCs.

Medicare Part D Outpatient Prescription Drug Coverage

In accordance with the Centers for Medicare & Medicaid Services requirements, the Senior Advantage Medicare Part D Catastrophic Coverage Stage threshold is increasing from \$6,350 to \$6,550 for calendar year 2021.

If your drug plan includes a Coverage Gap Stage, the Initial Coverage Stage threshold is increasing from \$4,020 to \$4,130 for calendar year 2021.

Opioid Treatment Program Services

- *In Medicare EOCs, Opioid Treatment Program Services will be covered at **no charge**.*

Prescription Drug Exclusion

Effective January 1, 2021, we are excluding prescription drugs with an over-the-counter equivalent, **to help maintain affordability**. We have added the following language under “Outpatient prescription drugs, supplies, and supplements exclusion(s)” in the “Benefits” section of non-Medicare EOCs:

- Prescription drugs for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug). This exclusion does not apply to:
 - ◆ insulin
 - ◆ over-the-counter drugs covered under “Preventive Services” in this “Benefits” section (this includes tobacco cessation drugs and contraceptive drugs)
 - ◆ an entire class of prescription drugs when one drug within that class becomes available over-the-counter
- Similar language has been added to Medicare EOCs for outpatient drugs, supplies, and supplements not covered by Medicare.

Residential Treatment Program for Mental Health and Substance Use Disorder

In Medicare EOCs with a Plan Deductible, services related to residential treatment programs for mental health and substance use disorder will be subject to the Plan Deductible.

Senior Advantage eligibility requirements

In Medicare EOCs, we have removed the following Senior Advantage eligibility requirements:

- The restriction for End-Stage Renal Disease (ESRD). The 21st Century Cures Act (CURES; P.L. 114-255) allows beneficiaries with ESRD the option to start enrolling in Medicare Advantage plans beginning in 2021
- The capacity limit restriction since it does not apply

Senior Advantage Service Area expansion

We have expanded our Southern California Region Senior Advantage Service Area in the following counties and zip codes, effective January 1, 2021:

- San Diego: 92003, 92028, 92059, 92060, 92061, 92086, and 92088
- Kern: 93249

Silver&Fit® Healthy Aging and Exercise Program

In Medicare EOCs that include Silver&Fit, effective January 1, 2021, Members will have the option to receive all of the following:

- Basic gym membership
- Two home fitness kits from a variety of kits
- One “Stay Fit” kit from several kits. A few kits include an activity tracker
- Previously, Members could choose one of the following options:
 - A basic gym membership
 - Two home fitness kits from a variety of kits

Global Clarifications to the Agreement, including EOC documents

About the Drug Formulary

In the “Outpatient Prescription Drugs, Supplies, and Supplements” section of EOCs, we have revised text under “About the drug formulary” for clarity and to better align with our drug formulary available on kp.org.

Age Limit of Dependent Children

Under “Age limit of Dependent children” in the “Eligibility as a Dependent” section of non-Medicare *EOCs*, we have clarified that a child must be under the age limit for Dependent children as of the effective date in order to enroll as a Dependent.

Calculating Premiums

Under “Calculating Premiums” in the *Agreement*, rate tables for Group coverage will no longer be consolidated when the rates for different categories of Members are the same. This may result in additional rate tables appearing in the *Agreement*.

Continuity drugs

We revised the continuity drug disclosure in all Medicare *EOCs* to remove cost share information, since continuity drugs are subject to the same cost share as would otherwise apply.

Emergency Medical Condition definition

We have updated the definition of Emergency Medical Condition in Medicare *EOCs* to add mental health conditions for clarity:

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

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

If You Have a Baby

Under “Eligibility as a Dependent” in non-Medicare *EOCs*, we have replaced the section “Newborn Coverage” with a new section titled “If you have a baby,” for clarity:

If you have a baby

If you have a baby while enrolled under this *EOC*, the baby is not automatically enrolled in this plan. The Subscriber must request enrollment of the baby as described under “Special enrollment” in the “How to Enroll and When Coverage Begins” section below. If the Subscriber does not request enrollment within this special enrollment period, the baby will only be covered under this plan for 31 days (including the date of birth), or until the date the baby is enrolled in other coverage, whichever happens first.

Preventive Services

In the “Preventive Services” section of non-Medicare *EOCs*, we have made the following changes for clarity:

- Simplified introductory language
- Added language explaining that certain preventive items listed on our website may not be covered in grandfathered plans

Prosthetics and Orthotics

In the “Prosthetics and Orthotics” section of *EOCs*, we have replaced the word “mastectomy” with the phrase “removal of all or part of a breast,” to align with terminology used elsewhere in the *EOC*. This is not a change in coverage.

Urgent Grievances (SB 1052)

Under “Urgent procedure” in the “Grievances” section of non-Medicare *EOCs*, we have clarified that urgent grievances are sometimes referred to as “exigent,” to align with state law. For clarity, we have also added two new bullet points to the list of grievances that may be considered urgent:

- You have received Emergency Services but have not been discharged from a facility and your request involves admissions, continued stay, or other health care Services
- You are undergoing a current course of treatment using a non-formulary prescription drug and your grievance involves a request to refill a non-formulary prescription drug

Calculating Premiums

To calculate the amount of Full Premiums that apply to a Family (a Subscriber and all of their Dependents):

1. Determine the coverage (*EOCs* and contract options) that apply to each Member in the Family (for example, Traditional Plan and any Ancillary Coverage).
2. Determine the family role type and Medicare status of each Member (for family role types, please see the “Definitions” section of the *EOC* for the definition of Subscriber, Dependent, and Spouse).
3. Identify the Premiums for each Member for each *EOC* and contract option (including contract options issued through a separate contract) based on the family role type and Medicare status of each Member:
 - Premiums for coverage issued under this *Agreement* appear in the Premium tables below.
 - If Ancillary Coverage has been issued under a separate contract and Premiums for that coverage are not listed in the Premium tables below, refer to that contract for Premiums. This Ancillary Coverage is part of the contract options selected by Group, and Group submits payment for this Ancillary Coverage as part of Full Premium.
4. Add the amount of Premiums for each Member together to arrive at the total, Full Premiums required for the Family.

Monthly Premiums for Kaiser Permanente Traditional HMO Plan — EOC # 1

TRADITIONAL HMO SCR

Members under age 65 who are not eligible for Medicare	
Family role type	Premiums
Subscriber	\$604.66
1st Dependent	\$604.65
2nd Dependent	\$501.87
Sponsored Dependent	\$604.66
Each additional Dependent	\$0.00

Members under age 65 who are eligible for or have Medicare Part A only	
Family role type	Premiums
Subscriber	\$604.66
1st Dependent	\$604.65
2nd Dependent	\$501.87
Sponsored Dependent	\$604.66
Each additional Dependent	\$0.00

Members under age 65 who are eligible for or have Medicare Part B only	
Family role type	Premiums
Subscriber	\$604.66
1st Dependent	\$604.65
2nd Dependent	\$501.87
Sponsored Dependent	\$604.66
Each additional Dependent	\$0.00

Members under age 65 who are eligible for or have Medicare Parts A&B	
Family role type	Premiums
Subscriber	\$604.66
1st Dependent	\$604.65
2nd Dependent	\$501.87
Sponsored Dependent	\$604.66

Members under age 65 who are eligible for or have Medicare Parts A&B	
Family role type	Premiums
Each additional Dependent	\$0.00

Members under age 65 who are enrolled in another carrier's Medicare Risk product	
Family role type	Premiums
Subscriber	\$1,657.55
1st Dependent	\$1,657.55
2nd Dependent	\$1,657.55
Sponsored Dependent	\$1,657.55
Each additional Dependent	\$1,657.55

Members under age 65 when Medicare is secondary	
Family role type	Premiums
Subscriber	\$604.66
1st Dependent	\$604.65
2nd Dependent	\$501.87
Sponsored Dependent	\$604.66
Each additional Dependent	\$0.00

Members age 65 and over whose Medicare eligibility is unknown	
Family role type	Premiums
Subscriber	\$1,657.55
1st Dependent	\$1,657.55
2nd Dependent	\$1,657.55
Sponsored Dependent	\$1,657.55
Each additional Dependent	\$1,657.55

Members age 65 and over who are eligible for or have Medicare Part A only	
Family role type	Premiums
Subscriber	\$1,295.72
1st Dependent	\$1,295.72
2nd Dependent	\$1,295.72
Sponsored Dependent	\$1,295.72
Each additional Dependent	\$1,295.72

Members age 65 and over who are eligible for or have Medicare Part B only	
Family role type	Premiums
Subscriber	\$1,657.55
1st Dependent	\$1,657.55
2nd Dependent	\$1,657.55
Sponsored Dependent	\$1,657.55
Each additional Dependent	\$1,657.55

Members age 65 and over who are eligible for or have Medicare Parts A&B	
Family role type	Premiums
Subscriber	\$1,295.72
1st Dependent	\$1,295.72

Members age 65 and over who are eligible for or have Medicare Parts A&B	
Family role type	Premiums
2nd Dependent	\$1,295.72
Sponsored Dependent	\$1,295.72
Each additional Dependent	\$1,295.72

Members age 65 and over who are enrolled in another carrier's Medicare Risk product	
Family role type	Premiums
Subscriber	\$1,657.55
1st Dependent	\$1,657.55
2nd Dependent	\$1,657.55
Sponsored Dependent	\$1,657.55
Each additional Dependent	\$1,657.55

Members age 65 and over when Medicare is secondary	
Family role type	Premiums
Subscriber	\$604.66
1st Dependent	\$604.65
2nd Dependent	\$501.87
Sponsored Dependent	\$604.66
Each additional Dependent	\$0.00

Note: Members who are “eligible for” Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who “have” Medicare Part A or B are those who have been granted Medicare Part A or B coverage. Medicare Part A provides inpatient coverage and Part B provides outpatient coverage.

Monthly Premiums for Kaiser Permanente Senior Advantage (HMO) with Part D — EOC # 2

SR ADV GRP HMO SCR

Family role type	Medicare Parts A & B	Medicare Part B only
Subscriber	\$226.51	\$537.51
1st Dependent	\$226.51	\$537.51
2nd Dependent	\$226.51	\$537.51
Sponsored Dependent	\$226.51	\$537.51
Each additional Dependent	\$226.51	\$537.51

Monthly Premiums for Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage — EOC # 3

SCR WORK AGED ASSIGN

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

Family role type	Premiums
Subscriber	\$604.66
1st Dependent	\$604.65
2nd Dependent	\$501.87
Sponsored Dependent	\$604.66

Monthly Premiums for American Specialty Health Plans Chiropractic Plan — EOC # 4

HMO CHIRO ACN SCR

Family role type	Premiums
Subscriber	\$1.70
1st Dependent	\$1.71
2nd Dependent	\$1.41
Sponsored Dependent	\$1.70

Enrollment Unit Chart

Contract name: UNIVERSITY OF SAN FRANCISCO

Group ID: 232239

Contract: 1

The charts below describe how the coverage your Group has purchased (called *contract options*) are organized into administrative groupings (called *enrollment units*) for the purposes of enrollment and billing. Please keep this document handy for future reference as the information it contains will be helpful when reporting membership changes.

An *Evidence of Coverage (EOC)* for each Health Plan coverage that your Group has purchased is incorporated into the enclosed *Group Agreement* (the *EOC* number is the same as the *contract option* number). If your Group has purchased non-Health Plan coverage (such as dental coverage), the carrier(s) for the applicable coverage will send its agreement to your Group under separate cover.

Contract option: A unique *contract option* name and number exists for each coverage option that you offer to your Members. For example, if you offer the same benefits to all of your Members, but have different eligibility rules for different segments of your membership, you will have a separate *contract option* for each coverage option.

Enrollment unit: An *enrollment unit* is a grouping of *contract options* for a specific segment of your Member population for enrollment and billing purposes. If there are *contract options* only available to a specific segment of your Member population, then there will be a distinct *enrollment unit* for that segment. If your Member population is billed separately, there will be a separate *enrollment unit* (or billing unit) for each segment. Note: An enrollment unit may also be referred to as a *subgroup*.

The following are the *enrollment units* associated with this contract:

Enrollment unit number: 4

Enrollment unit name: USF ACTIVE EMPLOYEES

Billing contact: CAROL CRUISE

Contract Option	Product name	Contract option name
1	Kaiser Permanente Traditional HMO Plan	TRADITIONAL HMO SCR
2	Kaiser Permanente Senior Advantage (HMO) with Part D	SR ADV GRP HMO SCR
3	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	SCR WORK AGED ASSIGN
4	American Specialty Health Plans Chiropractic Plan	HMO CHIRO ACN SCR

Enrollment unit number: 5

Enrollment unit name: USF P/T FACULTY REGIONAL

Billing contact: CAROL CRUISE

Contract Option	Product name	Contract option name
1	Kaiser Permanente Traditional HMO Plan	TRADITIONAL HMO SCR
2	Kaiser Permanente Senior Advantage (HMO) with Part D	SR ADV GRP HMO SCR
3	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	SCR WORK AGED ASSIGN
4	American Specialty Health Plans Chiropractic Plan	HMO CHIRO ACN SCR

Enrollment unit number: 7004

Enrollment unit name: USF ACTIVE EMPLOYEES / COBRA

Billing contact: CAROL CRUISE

Contract Option	Product name	Contract option name
1	Kaiser Permanente Traditional HMO Plan	TRADITIONAL HMO SCR
2	Kaiser Permanente Senior Advantage (HMO) with Part D	SR ADV GRP HMO SCR
3	Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	SCR WORK AGED ASSIGN
4	American Specialty Health Plans Chiropractic Plan	HMO CHIRO ACN SCR



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

A nonprofit corporation

Group Agreement for UNIVERSITY OF SAN FRANCISCO

Group ID: 232239 Contract: 1 Version: 10

January 1, 2021, through December 31, 2021

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Introduction

This Group Agreement (*Agreement*), including the *Evidence of Coverage (EOC)* and other document(s) listed below, the group application that Group submitted to Health Plan, and any amendments to any of them, all of which are incorporated into this *Agreement* by reference, constitute the contract between Kaiser Foundation Health Plan, Inc., (Health Plan) and UNIVERSITY OF SAN FRANCISCO (Group).

In consideration of timely payment of Premium, Health Plan will provide or arrange for covered Services to Members in accord with the following document(s):

Health Plan products, including Ancillary Coverage offered by Health Plan:

<u>Product name</u>	<u>Contract option name for product</u>	<u>EOC #</u>
Kaiser Permanente Traditional HMO Plan	TRADITIONAL HMO SCR	1
Kaiser Permanente Senior Advantage (HMO) with Part D	SR ADV GRP HMO SCR	2
Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage	SCR WORK AGED ASSIGN	3
American Specialty Health Plans Chiropractic Plan	HMO CHIRO ACN SCR	4

Pediatric dental coverage:

Not applicable

Other Ancillary Coverage:

Not applicable

In this *Agreement*, some capitalized terms have special meaning; please see the “Definitions” section in the *EOC* document(s) for definitions of terms that are used in *EOC* document(s) and this *Agreement*.

Term of Agreement and Renewal

Term of Agreement

Unless terminated as set forth in the “Termination of Agreement” section, this *Agreement* is effective from January 1, 2021, through December 31, 2021.

Renewal

This *Agreement* does not automatically renew. If Group complies with all of the terms of this *Agreement*, Health Plan will offer to renew the *Agreement*, upon 60 days prior written notice to Group, by doing one of the following:

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

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

Note: Your Group’s Anniversary Date is January 1.

Amendment of *Agreement*

Amendments Effective on your Group’s Anniversary Date

Upon 60 days prior written notice to Group, Health Plan may extend the term of this *Agreement* and make other changes by amending this *Agreement* effective January 1 (the Anniversary Date).

Amendments Related to Government Approval

If Health Plan notified Group that Health Plan had not received all necessary governmental approvals related to this *Agreement*, Health Plan may amend this *Agreement* by giving written notice to Group after receiving all necessary governmental approvals. Any such government-approved provisions go into effect on January 1, 2021 (unless the government requires a later effective date).

Amendment Due to Medicare Changes

Health Plan contracts on a calendar year basis with the Centers for Medicare & Medicaid Services (CMS) to offer Kaiser Permanente Senior Advantage. Health Plan may amend this *Agreement* to change any Kaiser Permanente Senior Advantage *EOCs* and Premiums effective January 1, 2022 (unless the federal government requires or allows a different effective date). The amendment may include an increase or decrease in Premiums and benefits (including Member Cost Sharing and any Medicare Part D coverage level thresholds). Health Plan will give Group written notice of any such amendment.

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

Amendment Due to Tax or Other Charges

If a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Health Plan or Plan Providers (or any of their activities), then upon 60 days prior written notice, Health Plan may increase Group’s Premiums to include Group’s share of the new or increased tax or charge. Group’s share will be determined by dividing the number of Members enrolled through Group by the total number of members enrolled in Health Plan’s Southern California Region.

Other Amendments

Health Plan may amend this *Agreement* at any time by giving written notice to Group, in order to address any law or regulatory requirement, which may include an increase in Premiums to reflect an increase in costs to Health Plan or Plan Providers (Health Plan will give Group 60 days prior written notice of any increase in Premiums or reduction in benefits).

Acceptance of Amendments

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

Termination of *Agreement*

This *Agreement* will terminate under any of the conditions listed below. All rights to benefits under this *Agreement* end on the termination date, except as expressly provided in the "Termination of Membership" or "Continuation of Membership" sections of an *Evidence of Coverage*. The termination date is the first day when this *Agreement* is no longer in effect (for example, if the termination date is January 1, 2022, the last minute this *Agreement* was in effect was at 11:59 p.m. on December 31, 2021).

If Health Plan terminates this *Agreement*, Health Plan will give Group written notice. In the case of "Termination for Nonpayment," "Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information," and "Termination for Discontinuance of a Product or all Products within a Market," Health Plan will provide both advance notice of the termination in addition to a final notice of termination. Within five business days of receipt of an advance or final notice of termination, Group will mail to each Subscriber a legible copy of the notice and will give Health Plan proof of that mailing and of the date thereof.

Termination on Notice

If Group has Kaiser Permanente Senior Advantage Members

If Group has Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, Group may terminate this *Agreement* effective January 1 (the Anniversary Date) by giving at least 30 days' prior written notice to Health Plan and remitting all amounts payable relating to this *Agreement*, including Premiums, for the period prior to the termination date.

If Group does not have Kaiser Permanente Senior Advantage Members

If Group does not have Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice from Group that it is terminating this *Agreement*, Group may terminate this *Agreement* effective January 1 (the Anniversary Date) by giving at least 15 days' prior written notice to Health Plan and remitting all amounts payable relating to this *Agreement*, including Premiums, for the period prior to the termination date.

Termination Due to Nonacceptance of Amendments

All amendments are deemed accepted by Group unless Group gives Health Plan written notice of nonacceptance within 15 days after the date of Health Plan's amendment notice and Group remits all amounts payable related to this *Agreement*, including Premiums, for the period prior to the amendment effective date, in which case this *Agreement* will terminate on the following date, as applicable:

- In the case of amendments described in the "Amendment of *Agreement*" section under "Amendments Related to Government Approval" and "Amendments Due to Medicare Changes," and amendments described under "Other Amendments" that do not require 60 days notice by Health Plan, if Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan receives written notice of nonacceptance, the termination date will be first of the month following 30 days after Health Plan receives written notice of nonacceptance
- In all other cases, the termination date will be the day before the effective date of the amendment

Termination for Nonpayment

Premiums are due for the Full Premium owed as described in the “Premiums” section. If Health Plan does not receive the required Premium payment for all coverage issued under this *Agreement* on or before the due date, we will send a notice of nonpayment to Group as described under “Notices” in the “Miscellaneous Provisions” section. This notice will include the following information:

- A statement that we have not received Full Premium payment and that we will terminate this *Agreement* for nonpayment if we do not receive the required Premiums by the specified date
- The amount of Premiums that are due

If we do not receive the required Premiums when due, the *Agreement* will terminate and all coverage issued under the *Agreement* will end on the date specified in the notice of nonpayment, which will be at least 30 days after the date of the notice. The *Agreement* will remain in effect during this grace period, but upon termination Group will be responsible for paying all past due Premiums, including the Premiums for this grace period.

We will mail a termination notice to Group as described under “Notices” in the “Miscellaneous Provisions” section if we do not receive Full Premium payment within 30 days after the date of the notice of nonreceipt of payment.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members, in order to comply with CMS termination notice requirements.

Termination for Fraud or Intentionally Furnishing Incorrect or Incomplete Information

If Group commits fraud or intentionally furnishes incorrect or incomplete material information to Health Plan, Health Plan may terminate this *Agreement* by giving advance written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members, in order to comply with CMS termination notice requirements.

Termination for Violation of Contribution or Participation Requirements

If Group fails to comply with Health Plan’s participation or contribution requirements (including those discussed in the “Contribution and Participation Requirements” section), Health Plan may terminate this *Agreement* by giving advance written notice to Group, and Group is liable for all unpaid Premiums up to the termination date.

If Group has Kaiser Permanente Senior Advantage Members enrolled under this *Agreement* at the time Health Plan gives written notice to Group, Health Plan may terminate this *Agreement* effective on one date with respect to Members other than Senior Advantage Members and effective on a later date with respect to Senior Advantage Members, in order to comply with CMS termination notice requirements.

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

Grandfathered products

Health Plan may terminate a particular product or all products offered in a small or large group market as permitted or required by law. If Health Plan discontinues offering a particular grandfathered product in a market, Health Plan may terminate this *Agreement* with respect to that product upon 90 days prior written notice to Group. Health Plan will offer Group another product that it makes available to groups in the small or large group market, as applicable. If Health Plan

discontinues offering all products to groups in a small or large group market, as applicable, Health Plan may terminate this *Agreement* upon 180 days prior written notice to Group and Health Plan will not offer any other product to Group. A “product” is a combination of benefits and services that is defined by a distinct *Evidence of Coverage*.

All other products

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

Contribution and Participation Requirements

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

Group must:

- Ensure that:
 - ◆ all Subscribers live or work inside the Service Area applicable to their coverage when they enroll (except that Group must ensure that Subscribers live inside the Service Area applicable to their coverage when they enroll if Group chooses not to have a “live or work” eligibility rule, and that Kaiser Permanente Senior Advantage Members live inside the Service Area applicable to their coverage when they enroll in Senior Advantage and thereafter)
 - ◆ at least one employee, proprietor, or partner who lives or works inside the Service Area is eligible to enroll as a Subscriber
- Meet all applicable legal and contractual requirements, such as:
 - ◆ meet all Health Plan requirements set forth in the “Rate Assumptions and Requirements” section of the *Rate Proposal* document (Group’s Health Plan account manager can provide Group with a copy of the Rate Proposal if Group does not have one)
 - ◆ offer enrollment in accord with eligibility requirements in state law (for example, domestic partners must be eligible if married spouses are eligible and disabled dependents must be eligible if dependent children are eligible)

Miscellaneous Provisions

Assignment

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

Attorney Fees and Costs

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

Confidential Information about Health Plan or its Affiliates

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

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

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

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

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

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

Monetary damages would not be a sufficient remedy for any breach or threatened breach of this “Confidential Information about Health Plan or its Affiliates” section. Health Plan will be entitled to equitable relief by way of injunction or specific performance if Group or any of its officers, directors, employees, attorneys, accountants, agents, advisors, or representatives breach, or threaten to breach, any of the provisions of this “Confidential Information about Health Plan or its Affiliates” section.

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

Contract Providers

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

Delegation of Claims Review

Group delegates to Health Plan the discretion to determine whether a Member is entitled to benefits under this *Agreement*. In making these determinations, Health Plan has discretionary authority to review claims in accord with the procedures contained in this *Agreement* and to construe this *Agreement* to determine whether the Member is entitled to benefits. If coverage under an *EOC* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), Health Plan is a “named claims fiduciary” to review claims under that *EOC*.

Enrollment Application Requirements

Group must use enrollment application forms that are provided by Health Plan. If Group wants to use a different form or system for enrolling Members, Group must obtain Health Plan’s approval of the form or system. Other forms and systems include a “universal” enrollment application form, interactive voice recording (IVR) enrollment system, or intranet online enrollment system. All forms and systems must meet Health Plan requirements for enrolling Members, including disclosure of binding arbitration in accord with Section 1363.1 of the California Health and Safety Code and other applicable law. Group must retain documentation of each Member’s acceptance of the use of binding arbitration, and upon request, must be able to produce documentation relating to a specific Member to Health Plan at any time. In the event that the contract between Health Plan and Group terminates or Group is unable to comply with this document retention requirement, Group must transfer possession of all such documentation to Health Plan in a mutually agreeable manner. Group’s Health Plan account manager can provide Group with Health Plan’s current requirements for enrollment application forms and systems.

Grandfathered Health Plan Coverage

For any coverage identified in an *EOC* as a “grandfathered health plan” under the Patient Protection and Affordable Care Act and regulations, Group must immediately inform Health Plan if this coverage does not meet (or no longer meets) the requirements for grandfathered status including but not limited to any change in its contribution rate to the cost of any grandfathered health plan(s) during the plan year. Group represents that, for any coverage identified as a “grandfathered health plan” in the applicable *EOC*, Group has not decreased its contribution rate more than five percent (5%) for any rate tier for such grandfathered health plan when compared to the contribution rate in effect on March 23, 2010 for the same plan. Health Plan will rely on Group’s representation in issuing and continuing any and all grandfathered health plan coverage.

Governing Law

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

Member Information

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

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

For each Health Plan coverage included in this *Agreement*, Health Plan will provide Group with the following disclosures for Group to distribute in accord with applicable laws, including the Medicare-as-Secondary-Payer laws (“Member Materials”):

- A *Disclosure Form (DF)* for each non-Medicare coverage. Group will provide *DFs* (or combined *DF/EOCs*) to Subscribers and potential Subscribers when the coverage is offered

- A *Summary of Benefits and Coverage (SBC)* for each non-Medicare coverage other than retiree plans with fewer than two current employees. Group will provide electronic or paper *SBCs* to Members and potential Members to the extent required by law, except that Health Plan will provide *SBCs* to Members who make a request to Health Plan
- Pre-enrollment materials that CMS requires for Kaiser Permanente Senior Advantage coverage, which are available upon request from Health Plan. Group will provide these materials to potential Members before they enroll in Senior Advantage coverage
- An *EOC* for each non-Medicare coverage. Group will provide *EOCs* (or combined *DF/EOCs*) to Subscribers, except that Health Plan will provide *EOCs* (or combined *DF/EOCs*) to Members and potential Members who make a request to Health Plan

If Group receives the *Agreement* or Member Materials in electronic form, Group is not authorized to modify or alter in any way the text or the formatting of the electronic *Agreement* or Member Materials.

Health Plan assumes no responsibility for any changes in text or formatting that may occur in the *Agreement* or Member Materials after they are provided to Group. If Group posts the electronic *Agreement* or Member Materials on its intranet site, it shall do so in such a way so as to permit employees of Group to download and print a complete and accurate copy of the *Agreement* or Member Materials.

In the event Health Plan reasonably concludes that Group is either using the electronic *Agreement* or Member Materials in a manner not permitted by this *Agreement* or is not providing Subscribers with access to the Member Materials in accord with applicable laws, then Health Plan will print copies of the *Agreement* or Member Materials and Group will cooperate with Health Plan to ensure that printed copies of the *Agreement* or Member Materials are provided in a timely manner to all employees of Group enrolled with Health Plan. Group agrees to reimburse Health Plan for the reasonable cost of printing and delivering the *Agreement* or Member Materials.

No Waiver

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

Notices

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

Notices from Health Plan to Group must be sent to:

DIANE SWEENEY, ASST DIR, BEN & COMP
 UNIVERSITY OF SAN FRANCISCO
 2130 FULTON ST
 SAN FRANCISCO, CA 94117-1080

If Group has chosen to receive group agreements electronically through Health Plan's website at **kp.org/yourcontract**, Health Plan will send a notice to Group at the address listed above when a group agreement has been posted to that website.

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

Notices from Group to Health Plan must be sent to:

Kaiser Permanente
1950 Franklin Street
Oakland, CA 94612
Attn: Wade J. Overgaard, Senior Vice President, Health Plan Operations

Open Enrollment

Group must hold an annual open enrollment period during which all eligible people, in accord with state law, may enroll in Health Plan or in any other health care plan available through Group. Also, Group must not hold open enrollment for 2022 until Group receives its 2022 group agreement Premium and coverage information from Health Plan. If Group holds the open enrollment without receiving 2022 group agreement Premium and coverage information, Health Plan may change Premiums and coverage (including benefits and Cost Sharing) when it offers to renew Group's Agreement as described under "Renewal" in the "Term of Agreement and Renewal" section

Other Group coverage that covers Essential Health Benefits

For each non-grandfathered non-Medicare Health Plan coverage, except for any retiree-only coverage, Group must do all of the following if Group provides Health Plan Members with other medical or dental coverage (for example, separate pharmacy coverage) that covers any Essential Health Benefits:

- Notify Health Plan of the out-of-pocket maximum (OOPM) that applies to the Essential Health Benefits in each of the other medical or dental coverage.
- Ensure that the sum of the OOPM in Health Plan's coverage plus the OOPMs that apply to Essential Health Benefits in all of the other medical and dental coverage does not exceed the annual limitation on cost sharing described in 45 CFR 156.130.

Reporting Membership Changes and Retroactivity

Group must report membership changes (including sending appropriate membership forms) within the time limit for retroactive changes and in accord with any applicable "rescission" provisions of the Patient Protection and Affordable Care Act and regulations. Except for Senior Advantage membership terminations discussed below, the time limit for retroactive membership changes is the calendar month when Health Plan's California Service Center receives Group's notification of the change plus the previous 2 months.

Representation regarding communication of membership changes

Group represents that its communication regarding membership changes to Health Plan is accurate. Group and its representative are bound by all membership data, including any changes or updates that it, or its representative, submits to Health Plan via any medium, electronic or otherwise, including but not limited to the following:

- Electronic data submissions regarding enrollment and eligibility
- Health Plan approved online tool for submission of data
- Paper enrollments submitted through postal mail or fax

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

Involuntary Kaiser Permanente Senior Advantage Membership Terminations

Group must give Health Plan's California Service Center 30 days' prior written notice of Senior Advantage involuntary membership terminations. An involuntary membership termination is a termination that is not in response to a disenrollment notice issued by CMS to Health Plan or received by Health Plan directly from a Member (these events are usually in response to a Member's request for disenrollment to CMS because the Member has enrolled in another Medicare

health plan or wants Original Medicare coverage or has lost Medicare eligibility). The membership termination date is the first of the month following 30 days after the date when Health Plan's California Service Center receives a Senior Advantage membership termination notice unless Group specifies a later termination date. For example, if Health Plan's California Service Center receives a termination notice on March 5 for a Senior Advantage Member, the earliest termination date is May 1 and Group is required to pay applicable Premiums for the months of March and April.

Voluntary Kaiser Permanente Senior Advantage Membership Terminations

If Health Plan's California Service Center receives a disenrollment notice from CMS or a membership termination request from the Member, the membership termination date will be in accord with CMS requirements.

Representation Regarding Waiting Periods

By entering into this Agreement, Group hereby represents that Group does not impose a waiting period exceeding 90 days on employees who meet Group's eligibility requirements. For purposes of this requirement, a "waiting period" is the period that must pass before coverage for an individual who is otherwise eligible to enroll in non-Medicare coverage under the terms of a group health plan can become effective in accord with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations.

In addition, Group represents that eligibility data provided by the Group to Health Plan will include coverage effective dates for Group's employees that correctly account for eligibility in compliance with the waiting period requirements in the Patient Protection and Affordable Care Act and regulations and will not exceed the waiting period established by Group. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: If the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

Right to Examine Records

Upon reasonable notice, Health Plan may examine Group's records with respect to contribution and participation requirements, eligibility, and payments under this *Agreement*.

Social Security and Tax Identification Numbers

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

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

Premiums

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

Due Date and Payment of Premiums

The payment due date for each enrollment unit (or subgroup) associated with Group will be reflected on the monthly membership invoice if applicable to Group (if not applicable, then as specified in writing by Health Plan). If Group does

not pay Full Premiums by the first of the coverage month, the Premiums may include an additional administrative charge upon renewal. "Full Premiums" means 100 percent of monthly Premiums for all of the coverage issued to each enrolled Member, as set forth under "Calculating Premiums" in this "Premiums" section.

New Members

Premiums are payable for the entire month for a new Member whose coverage effective date falls between the first day of the month and the fifteenth day of the month. No Premiums are due for the month for a new Member whose coverage becomes effective after the fifteenth day of that month.

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

Membership Termination

Premiums are payable for the entire month for a Member whose last day of coverage is any day during that month.

Note: The membership termination date is the first day a Member is not covered (for example, if the termination date is January 1, 2022, the last minute of coverage was at 11:59 p.m. on December 31, 2021).

Involuntary Kaiser Permanente Senior Advantage Membership Terminations

Group must give Health Plan's California Service Center 30 days' prior written notice of Senior Advantage involuntary membership terminations. An involuntary membership termination is a termination that is not in response to a disenrollment notice issued by CMS to Health Plan or received by Health Plan directly from a Member (these events are usually in response to a Member's request for disenrollment to CMS because the Member has enrolled in another Medicare health plan or wants Original Medicare coverage or has lost Medicare eligibility). The membership termination date is the first of the month following 30 days after the date when Health Plan's California Service Center receives a Senior Advantage membership termination notice unless Group specifies a later termination date. For example, if Health Plan's California Service Center receives a termination notice on March 5 for a Senior Advantage Member, the earliest termination date is May 1 and Group is required to pay applicable Premiums for the months of March and April.

Voluntary Kaiser Permanente Senior Advantage Membership Terminations

If Health Plan's California Service Center receives a disenrollment notice from CMS or a membership termination request from the Member, the membership termination date will be in accord with CMS requirements.

Premium Rebates

If state or federal law requires Health Plan to rebate premiums from this or any earlier contract year and Health Plan rebates premiums to Group, Group represents that Group will use that rebate for the benefit of Members, in a manner consistent with the requirements of the Public Health Service Act and the Affordable Care Act and if applicable with the obligations of a fiduciary under the Employee Retirement Income Security Act (ERISA).

Medicare

Medicare as primary coverage

For Members who are (or the subscriber in the family is) retired, age 65 or over, and eligible for Medicare as primary coverage, Premiums are based on the assumption that Health Plan or its designee will receive Medicare payments for Medicare-covered services provided to Members whose Medicare coverage is primary. If a Member age 65 or over is (or becomes) eligible for Medicare as primary coverage and is not for any reason enrolled through Group under a Kaiser Permanente Senior Advantage *EOC* (including inability to enroll under that *EOC* because they do not meet the plan's eligibility requirements, the plan is not available through Group, or the plan is closed to enrollment), Group must pay the Premiums listed below for the *EOC* under which the Member is enrolled that apply to Members age 65 or over who are not enrolled through Group under one of Health Plan's Medicare plans.

If a Member age 65 or over who is eligible for Medicare as primary coverage and enrolled under a Kaiser Permanente Senior Advantage *EOC* is no longer eligible for that plan, Health Plan may transfer the Member's membership to one of Group's plans that does not require Members to have Medicare, and Group must pay the Premiums listed below for the *EOC* under which the Member is enrolled that apply to Members age 65 or over who are not enrolled through Group under one of Health Plan's Medicare plans.

Medicare as secondary coverage

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

Subscriber Contributions for Medicare Part C and Part D Coverage

Medicare Part C coverage

This "Medicare Part C coverage" section applies to Group's Kaiser Permanente Senior Advantage coverage. Group's Senior Advantage Premiums include the Medicare Part C premium for coverage of items and services covered under Parts A and B of Medicare, and supplemental benefits. Group may determine how much it will require Subscribers to contribute toward the Medicare Part C premium for each Senior Advantage Member in the Subscriber's Family, subject to the following restrictions:

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part C premium, then Group agrees to the following:
 - ◆ any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job category
 - ◆ Group will not require different Subscriber contributions toward the Medicare Part C premium for Members within the same class
- Group will not require Subscribers to pay a contribution for Medicare Part C coverage for a Senior Advantage Member that exceeds the Medicare Part C Premium for items and services covered under Parts A and B of Medicare, and supplemental benefits. As applicable, Health Plan will pass through monthly payments received from CMS (the monthly payments described in 42 C.F.R. 422.304(a)) to reduce the amount the Member contributes toward the Medicare Part C premium

Medicare Part D coverage

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

- If Group requires different contribution amounts for different classes of Senior Advantage Members for the Medicare Part D premium, then Group agrees to the following:
 - ◆ any such differences in classes of Members are reasonable and based on objective business criteria, such as years of service, business location, and job category, and are not based on eligibility for the Medicare Part D Low Income Subsidy (the subsidies described in 42 C.F.R. Section 423 Subpart P, which are offered by the Medicare program to certain low-income Medicare beneficiaries enrolled in Medicare Part D, and which reduce the Medicare beneficiaries' Medicare Part D premiums and/or Medicare Part D cost-sharing amounts)
 - ◆ Group will not require different Subscriber contributions toward the Medicare Part D premium for Members within the same class
- Group will not require Subscribers to pay a contribution for prescription drug coverage for a Senior Advantage Member that exceeds the Premium for prescription drug coverage (including the Medicare Part D premium). The Group will pass

through direct subsidy payments received from CMS to reduce the amount the Member contributes toward the Medicare Part D premium

- Health Plan will credit Group with any Low Income Subsidy amounts that Health Plan receives from CMS for Group’s Members, and Health Plan will identify those Members for Group as required by CMS. For those Members, Group will first credit the Low Income Subsidy amount toward the Subscriber’s contribution for that Member’s Senior Advantage Premium for the same month, and will then apply any remaining portion of the Member’s Low Income Subsidy toward the portion of the Senior Advantage Premium that Group pays on behalf of that Member for that month. If Group is unable to reduce the Subscriber’s contribution before the Subscriber makes the contribution, Group shall, consistent with CMS guidance, refund the Low Income Subsidy amount to the Subscriber (up to the amount of the Subscriber Premium contribution for the Member for that month) within 45 days after the date Health Plan receives the Low Income Subsidy amount from CMS. Health Plan reserves the right to periodically require Group to certify that Group is either reducing Subscribers’ monthly Premium contributions or refunding the Low Income Subsidy amounts to Subscribers in accord with CMS guidance
- For any Members who are eligible for the Low Income Subsidy, if the amount of that Low Income Subsidy is less than the Member’s contribution for the Medicare Part D premium, then Group should inform the Member of the financial consequences of the Member’s enrolling in the Member’s current coverage, as compared to enrolling in another Medicare Part D plan with a monthly premium equal to or less than the Low Income Subsidy amount

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

Calculating Premiums

To calculate the amount of Full Premiums that apply to a Family (a Subscriber and all of their Dependents):

1. Determine the coverage (*EOCs* and contract options) that apply to each Member in the Family (for example, Traditional Plan and any Ancillary Coverage).
2. Determine the family role type and Medicare status of each Member (for family role types, please see the “Definitions” section of the *EOC* for the definition of Subscriber, Dependent, and Spouse).
3. Identify the Premiums for each Member for each *EOC* and contract option (including contract options issued through a separate contract) based on the family role type and Medicare status of each Member:
 - Premiums for coverage issued under this *Agreement* appear in the Premium tables below.
 - If Ancillary Coverage has been issued under a separate contract and Premiums for that coverage are not listed in the Premium tables below, refer to that contract for Premiums. This Ancillary Coverage is part of the contract options selected by Group, and Group submits payment for this Ancillary Coverage as part of Full Premium.
4. Add the amount of Premiums for each Member together to arrive at the total, Full Premiums required for the Family.

Monthly Premiums for Kaiser Permanente Traditional HMO Plan — EOC #1

TRADITIONAL HMO SCR

Members under age 65 who are not eligible for Medicare	
Family role type	Premiums
Subscriber	\$604.66
1st Dependent	\$604.65
2nd Dependent	\$501.87
Sponsored Dependent	\$604.66
Each additional Dependent	\$0.00

Members under age 65 who are eligible for or have Medicare Part A only	
Family role type	Premiums
Subscriber	\$604.66

Members under age 65 who are eligible for or have Medicare Part A only	
Family role type	Premiums
1st Dependent	\$604.65
2nd Dependent	\$501.87
Sponsored Dependent	\$604.66
Each additional Dependent	\$0.00

Members under age 65 who are eligible for or have Medicare Part B only	
Family role type	Premiums
Subscriber	\$604.66
1st Dependent	\$604.65
2nd Dependent	\$501.87
Sponsored Dependent	\$604.66
Each additional Dependent	\$0.00

Members under age 65 who are eligible for or have Medicare Parts A&B	
Family role type	Premiums
Subscriber	\$604.66
1st Dependent	\$604.65
2nd Dependent	\$501.87
Sponsored Dependent	\$604.66
Each additional Dependent	\$0.00

Members under age 65 who are enrolled in another carrier's Medicare Risk product	
Family role type	Premiums
Subscriber	\$1,657.55
1st Dependent	\$1,657.55
2nd Dependent	\$1,657.55
Sponsored Dependent	\$1,657.55
Each additional Dependent	\$1,657.55

Members under age 65 when Medicare is secondary	
Family role type	Premiums
Subscriber	\$604.66
1st Dependent	\$604.65
2nd Dependent	\$501.87
Sponsored Dependent	\$604.66
Each additional Dependent	\$0.00

Members age 65 and over whose Medicare eligibility is unknown	
Family role type	Premiums
Subscriber	\$1,657.55
1st Dependent	\$1,657.55
2nd Dependent	\$1,657.55
Sponsored Dependent	\$1,657.55
Each additional Dependent	\$1,657.55

Members age 65 and over who are eligible for or have Medicare Part A only	
Family role type	Premiums
Subscriber	\$1,295.72
1st Dependent	\$1,295.72
2nd Dependent	\$1,295.72
Sponsored Dependent	\$1,295.72
Each additional Dependent	\$1,295.72

Members age 65 and over who are eligible for or have Medicare Part B only	
Family role type	Premiums
Subscriber	\$1,657.55
1st Dependent	\$1,657.55
2nd Dependent	\$1,657.55
Sponsored Dependent	\$1,657.55
Each additional Dependent	\$1,657.55

Members age 65 and over who are eligible for or have Medicare Parts A&B	
Family role type	Premiums
Subscriber	\$1,295.72
1st Dependent	\$1,295.72
2nd Dependent	\$1,295.72
Sponsored Dependent	\$1,295.72
Each additional Dependent	\$1,295.72

Members age 65 and over who are enrolled in another carrier's Medicare Risk product	
Family role type	Premiums
Subscriber	\$1,657.55
1st Dependent	\$1,657.55
2nd Dependent	\$1,657.55
Sponsored Dependent	\$1,657.55
Each additional Dependent	\$1,657.55

Members age 65 and over when Medicare is secondary	
Family role type	Premiums
Subscriber	\$604.66
1st Dependent	\$604.65
2nd Dependent	\$501.87
Sponsored Dependent	\$604.66
Each additional Dependent	\$0.00

Note: Members who are “eligible for” Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who “have” Medicare Part A or B are those who have been granted Medicare Part A or B coverage. Medicare Part A provides inpatient coverage and Part B provides outpatient coverage.

Monthly Premiums for Kaiser Permanente Senior Advantage (HMO) with Part D — EOC # 2

SR ADV GRP HMO SCR

Family role type	Medicare Parts A & B	Medicare Part B only
Subscriber	\$226.51	\$537.51
1st Dependent	\$226.51	\$537.51
2nd Dependent	\$226.51	\$537.51
Sponsored Dependent	\$226.51	\$537.51
Each additional Dependent	\$226.51	\$537.51

Monthly Premiums for Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage — EOC # 3

SCR WORK AGED ASSIGN

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

Family role type	Premiums
Subscriber	\$604.66
1st Dependent	\$604.65
2nd Dependent	\$501.87
Sponsored Dependent	\$604.66

Monthly Premiums for American Specialty Health Plans Chiropractic Plan — EOC # 4

HMO CHIRO ACN SCR

Family role type	Premiums
Subscriber	\$1.70
1st Dependent	\$1.71
2nd Dependent	\$1.41
Sponsored Dependent	\$1.70

Agreement Signature Page

Acceptance of Agreement

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

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

Binding Arbitration

As more fully set forth in the arbitration provision in the applicable *Evidence of Coverage*, disputes between Members, their heirs, relatives, or associated parties (on the one hand) and Health Plan, Kaiser Permanente health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising out of or related to this *Agreement*, including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items pursuant to this *Agreement*, irrespective of legal theory, must be decided by binding arbitration and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Members enrolled under this *Agreement* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration as specified in the applicable *Evidence of Coverage* except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeals procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

Signatures

UNIVERSITY OF SAN FRANCISCO

Kaiser Foundation Health Plan, Inc.
Southern California Region



Authorized Group officer signature

Wade J. Overgaard
Authorized officer
Senior Vice President, Health Plan Operations

Please print your name and title

Executed in San Diego, CA effective 1/1/21
Date: 12/3/20

Date signed

Please keep this copy with your Agreement . An extra copy of the Signature Page is enclosed for mailing to Health Plan's California Service Center at P.O. Box 23448, San Diego, CA 92193-3448.



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

A nonprofit corporation

EOC #1 - Kaiser Permanente Traditional HMO Plan Evidence of Coverage for UNIVERSITY OF SAN FRANCISCO

Group ID: 232239 Contract: 1 Version: 10 EOC Number: 1

January 1, 2021, through December 31, 2021

Member Service Contact Center
24 hours a day, seven days a week (except closed holidays)
1-800-464-4000 (TTY users call **711**)
kp.org

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, materials translated into your language, or in alternative formats. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: خدمات الترجمة الفورية متوفرة لك مجاناً على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمة الهاتف النصي يرجى الاتصال على الرقم (711).

Armenian: Ձեզ կարող է անվճար օգնություն տրամադրվել լեզվի հարցում՝ օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Պարզապես զանգահարեք մեզ՝ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ՝ շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711**:

Chinese: 您每週7天，每天24小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。我們每週7天，每天24小時均歡迎您打電話**1-800-757-7585** 前來聯絡（節假日休息）。聽障及語障專線 (TTY) 使用者請撥**711**。

Farsi: خدمات زبانی در 24 ساعت شبانروز و 7 روز هفته بدون اخذ هزینه در اختیار شما است. شما می توانید برای خدمات مترجم شفاهی، ترجمه جزوات به زبان شما و یا به صورتهای دیگر درخواست کنید. کافیتست در 24 ساعت شبانروز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران TTY با شماره **711** تماس بگیرند.

Hindi: बनिा कसिी लागत के दुभाषया सेवाएँ, दनि के 24 घंटे, सप्ताह के सातों दनि उपलब्ध हैं। आप एक दुभाषया की सेवाओं के लिए, बनिा कसिी लागत के सामग्रयिों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पकि प्रारूपों के लिए अनुरोध कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दनि के 24 घंटे, सप्ताह के सातों दनि (छुट्टयिों वाले दनि बंद रहता है) कॉल करें। TTY उपयोगकर्ता **711** पर कॉल करें।

Hmong: Muajkw pab txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom. Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu **711**.

Japanese: 当院では、言語支援を無料で、年中無休、終日ご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは資料を別の書式でも依頼できます。お気軽に **1-800-464-4000** までお電話ください（祭日を除き年中無休）。TTYユーザーは**711**にお電話ください。

Khmer: ជំនួយភាសា គឺមានឥតអស់ថ្លៃដល់អ្នកឡើយ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ សំភារៈដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទម្រង់ផ្សេងទៀត។ គ្រាន់តែទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711**។

Korean: 요일 및 시간에 관계없이 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스, 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000**번으로 전화하십시오 (공휴일 휴무). TTY 사용자 번호 **711**.

Laotian: ການຊ່ວຍເຫຼືອດ້ານພາສາມາດໃຫ້ໂດຍບໍ່ເສັຽຄ່າແກ່ທ່ານ, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ. ທ່ານສາມາດຮ້ອງຂໍບໍລິການນາຍພາສາ, ໃຫ້ແປອອກສາຍພາສາຂອງທ່ານ, ຫຼືໃບຮູບແບບອື່ນ. ພາສາຕາໂທສຫາພວກເຮົາທີ່ **1-800-464-4000**, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ (ບໍ່ວັນພັກຕ່າງໆ). ຜູ້ໃຊ້ສາຍ TTY ໂທສ **711**.

Navajo: Saad bee áká'a'ayeed náhóló t'áá jiik'é, naadiin doo bibaa' dji' ahé'íikeed tsosts'id yiskáají damoo ná'ádleehjí. Atah halne'é áká'adoolwołigíí jókí, t'áadoo le'é t'áá hóhazaadjí hadilyaa'go, éí doodaii' nááná lá al'aa ádaat'ehígíí bee hádadilyaa'go. Kojí hodiilnih **1-800-464-4000**, naadiin doo bibaa' dji' ahé'íikeed tsosts'id yiskáají damoo ná'ádleehjí (Dahodiyin biniyé e'e'aahgo éí da'deelkaal). TTY chodeeyoolínígíí kojí hodiilnih **711**.

Punjabi: ਬਨਿੰ ਕਮਿ ਲਾਗਤ ਦੇ, ਦਨਿ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਨਿ, ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲਈ, ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਮਿ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਬਸ ਸਰਿਫ ਸਾਨੂੰ **1-800-464-4000** ਤੇ, ਦਨਿ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਨਿ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਨਿ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫੋਨ ਕਰੋ। TTY ਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711** 'ਤੇ ਫੋਨ ਕਰਨ।

Russian: Мы бесплатно обеспечиваем Вас услугами перевода 24 часа в сутки, 7 дней в неделю. Вы можете воспользоваться помощью устного переводчика, запросить перевод материалов на свой язык или запросить их в одном из альтернативных форматов. Просто позвоните нам по телефону **1-800-464-4000**, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру **711**.

Spanish: Contamos con asistencia de idiomas sin costo alguno para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al **711**.

Tagalog: May magagamit na tulong sa wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo. Maaari kang humingi ng mga serbisyo ng tagasalin sa wika, mga babasahin na isinalin sa iyong wika o sa mga alternatibong format. Tawagan lamang kami sa **1-800-464-4000**, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa **711**.

Thai: เรามีบริการสามฟรีสำหรับคุณตลอด 24 ชั่วโมงทุกวันตลอดชั่วโมงทำการของเรา คุณสามารถขอให้สามช่วยตอบคำถามของคุณที่เกี่ยวข้องกับความคุ้มครองการดูแลสุขภาพของเรา และคุณยังสามารถขอให้มีการแปลเอกสารเป็นภาษาที่คุณใช้ได้โดยไม่มีค่าธรรมเนียมบริการ เพียงโทรหาเราที่หมายเลข **1-800-464-4000** ตลอด 24 ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้ TTY โปรดโทรไปที่ **711**.

Vietnamese: Dịch vụ thông dịch được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. Quý vị chỉ cần gọi cho chúng tôi tại số **1-800-464-4000**, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi **711**.

Nondiscrimination Notice

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Service Contact Center 24 hours a day, 7 days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. Auxiliary aids and services for individuals with disabilities are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. You may request materials translated in your language at no cost to you. You may also request these materials in large text or in other formats to accommodate your needs at no cost to you. For more information, call **1-800-464-4000** (TTY **711**).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage or Certificate of Insurance* or speak with a Member Services representative for the dispute-resolution options that apply to you.

You may submit a grievance in the following ways:

- **By phone:** Call member services at **1-800-464-4000** (TTY **711**) 24 hours a day, 7 days a week (except closed holidays).
- **By mail:** Call us at **1-800-464-4000** (TTY **711**) and ask to have a form sent to you.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at **kp.org/facilities** for addresses)
- **Online:** Use the online form on our website at **kp.org**

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at:

Northern California

Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California

Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH

Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TTY). Complaint forms are available at [hhs.gov/ocr/office/file/index.html](https://www.hhs.gov/ocr/office/file/index.html).

Aviso de no discriminación

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros brinda servicios de asistencia con el idioma las 24 horas del día, los 7 días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. Se ofrecen aparatos y servicios auxiliares para personas con discapacidades sin costo alguno durante el horario de atención. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Puede solicitar los materiales traducidos a su idioma sin costo para usted. También los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades sin costo para usted. Para obtener más información, llame al **1-800-788-0616** (TTY **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura* (*Evidence of Coverage*) o *Certificado de Seguro* (*Certificate of Insurance*), o comuníquese con un representante de Servicio a los Miembros para conocer las opciones de resolución de disputas que le corresponden.

Puede presentar una queja de las siguientes maneras:

- **Por teléfono:** Llame a servicio a los miembros al **1-800-788-0616** (TTY **711**) las 24 horas del día, los 7 días de la semana (excepto los días festivos).
- **Por correo postal:** Llámenos al **1-800-788-0616** (TTY **711**) y pida que se le envíe un formulario.
- **En persona:** Llene un formulario de Queja Formal o Reclamo/Solicitud de Beneficios en una oficina de servicio a los miembros ubicada en un Centro de Atención del Plan (consulte su directorio de proveedores en **kp.org/facilities**[haga clic en “Español”] para obtener las direcciones).
- **En línea:** Use el formulario en línea en nuestro sitio web en **kp.org/espanol**.

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al Coordinador de Derechos Civiles de Kaiser Permanente (Civil Rights Coordinator) de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en:

Northern California

Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California

Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U.S. Department of Health and Human Services) mediante el Portal de Quejas Formales de la Oficina de Derechos Civiles (Office for Civil Rights Complaint Portal), en ocrportal.hhs.gov/ocr/portal/lobby.jsf (en inglés) o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TTY). Los formularios de queja formal están disponibles en hhs.gov/ocr/office/file/index.html (en inglés).

無歧視公告

Kaiser Permanente禁止以年齡、人種、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達、性取向、婚姻狀況、生理或心理殘障、付款來源、遺傳資訊、公民身份、主要語言或移民身份為由而歧視任何人。

會員服務聯絡中心每週7天每天24小時提供語言協助服務（節假日除外）。本機構在全部營業時間內免費為您提供口譯服務，包括手語服務，以及殘障人士輔助器材和服務。我們還可為您和您的親友提供使用本機構設施與服務所需要的任何特別協助。您可免費索取翻譯成您的語言的資料。您還可免費索取符合您需求的大號字體或其他格式的版本。若需更多資訊，請致電**1-800-757-7585**（TTY 711）。

申訴指任何您或您的授權代表透過申訴程序來表達不滿的做法。例如，如果您認為自己受到歧視，即可提出申訴。若需瞭解適用於自己的爭議解決選項，請參閱《承保範圍說明書》(Evidence of Coverage)或《保險證明書》(Certificate of Insurance)，或諮詢會員服務代表。

您可透過以下方式提出申訴：

- **透過電話：**請致電**1-800-757-7585**（TTY 711）與會員服務部聯絡，服務時間為每週7天，每天24小時（節假日除外）。
- **透過郵件：**請致電**1-800-757-7585**（TTY 711）與我們聯絡並請我們將表格寄給您。
- **親自遞交：**在計劃設施的會員服務辦事處填寫投訴或福利理索賠 / 申請表（請參閱 kp.org/facilities 上的保健業者名錄以查看地址）
- **線上：**使用我們網站上的線上表格，網址為 kp.org

如果您在提交申訴時需要協助，請致電我們的會員服務聯絡中心。

涉及人種、膚色、原國籍、性別、年齡或殘障歧視的一切申訴都將通知Kaiser Permanente的民權事務協調員 (Civil Rights Coordinator)。您也可與Kaiser Permanente的民權事務協調員直接聯絡，地址：

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

您還可以電子方式透過民權辦公室的投訴入口網站 (Office for Civil Rights Complaint Portal) 向美國衛生與民眾服務部 (U.S. Department of Health and Human Services) 民權辦公室 (Office for Civil Rights) 提出民權投訴，網址是 ocrportal.hhs.gov/ocr/portal/lobby.jsf 或者按照如下資訊採用郵寄或電話方式聯絡：U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TTY)。投訴表可從網站 hhs.gov/ocr/office/file/index.html 下載。

Thông Báo Không Kỳ Thị

Kaiser Permanente không phân biệt đối xử dựa trên tuổi tác, chủng tộc, sắc tộc, màu da, nguyên quán, hoàn cảnh văn hóa, tổ tiên, tôn giáo, giới tính, nhận dạng giới tính, cách thể hiện giới tính, khuynh hướng tình dục, gia cảnh, khuyết tật về thể chất hoặc tinh thần, nguồn tiền thanh toán, thông tin di truyền, quốc tịch, ngôn ngữ chính, hay tình trạng di trú.

Các dịch vụ trợ giúp ngôn ngữ hiện có từ Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi 24 giờ trong ngày, 7 ngày trong tuần (ngoại trừ ngày lễ). Dịch vụ thông dịch, kể cả ngôn ngữ ký hiệu, được cung cấp miễn phí cho quý vị trong giờ làm việc. Các phương tiện trợ giúp và dịch vụ bổ sung cho những người khuyết tật được cung cấp miễn phí cho quý vị trong giờ làm việc. Chúng tôi cũng có thể cung cấp cho quý vị, gia đình và bạn bè quý vị mọi hỗ trợ đặc biệt cần thiết để sử dụng cơ sở và dịch vụ của chúng tôi. Quý vị có thể yêu cầu miễn phí tài liệu được dịch ra ngôn ngữ của quý vị. Quý vị cũng có thể yêu cầu miễn phí các tài liệu này dưới dạng chữ lớn hoặc dưới các dạng khác để đáp ứng nhu cầu của quý vị. Để biết thêm thông tin, gọi **1-800-464-4000 (TTY 711)**.

Một phần nài là bất cứ thể hiện bất mãn nào được quý vị hay vị đại diện được ủy quyền của quý vị trình bày qua thủ tục phàn nàn. Ví dụ, nếu quý vị tin rằng chúng tôi đã kỳ phân biệt đối xử với vị, quý vị có thể đệ đơn phàn nàn. Vui lòng tham khảo *Chứng Từ Bảo Hiểm (Evidence of Insurance)* hay *Chứng Nhận Bảo Hiểm (Certificate of Insurance)*, hoặc nói chuyện với một nhân viên ban Dịch Vụ Hội Viên để biết các lựa chọn giải quyết tranh chấp có thể áp dụng cho quý vị.

Quý vị có thể nộp đơn phàn nàn bằng các hình thức sau đây:

- **Qua điện thoại:** Gọi cho ban dịch vụ hội viên theo số **1-800-464-4000 (TTY 711)** 24 giờ trong ngày, 7 ngày trong tuần (ngoại trừ đóng cửa ngày lễ).
- **Qua bưu điện:** Gọi cho chúng tôi theo số **1-800-464-4000 (TTY 711)** và yêu cầu được gửi một mẫu đơn.
- **Trực tiếp:** Điền một mẫu đơn Than Phiền hay Yêu Cầu Quyền Lợi/Yêu Cầu tại một văn phòng ban dịch vụ hội viên tại một Cơ Sở Thuộc Chương Trình (xem danh mục nhà cung cấp của quý vị tại **kp.org/facilities** để biết địa chỉ)
- **Trực tuyến:** Sử dụng mẫu đơn trực tuyến trên trang mạng của chúng tôi tại **kp.org**

Xin gọi Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi nếu quý vị cần trợ giúp nộp đơn phàn nàn.

Điều Phối Viên Dân Quyền (Civil Rights Coordinator) Kaiser Permanente sẽ được thông báo về tất cả phàn nàn liên quan tới việc kỳ thị trên cơ sở chủng tộc, màu da, nguyên quán, giới tính, tuổi tác, hay tình trạng khuyết tật. Quý vị cũng có thể liên lạc trực tiếp với Điều Phối Viên Dân Quyền Kaiser Permanente tại:

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

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Quý vị cũng có thể đệ đơn than phiền về dân quyền với Bộ Y Tế và Nhân Sinh Hoa Kỳ (U.S. Department of Health and Human Services), Phòng Dân Quyền (Office of Civil Rights) bằng

đường điện tử thông qua Cổng Thông Tin Phòng Phụ Trách Khiếu Nại về Dân Quyền (Office for Civil Rights Complaint Portal), hiện có tại ocrportal.hhs.gov/ocr/portal/lobby.jsf, hay bằng đường bưu điện hoặc điện thoại tại: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TTY).
Mẫu đơn than phiền hiện có tại hhs.gov/ocr/office/file/index.html.

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Cost Share Summary

This “Cost Share Summary” is part of your Evidence of Coverage (*EOC*) and is meant to explain the amount you will pay for covered Services under this plan. It does not provide a full description of your benefits. For a full description of your benefits, including any limitations and exclusions, please read this entire *EOC*, including any amendments, carefully.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Deductible(s) and Out-of-Pocket Maximum(s)

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.

Amounts Per Accumulation Period	Self-Only Coverage (a Family of one Member)	Family Coverage Each Member in a Family of two or more Members	Family Coverage Entire Family of two or more Members
Plan Deductible	None	None	None
Drug Deductible	None	None	None
Plan Out-of-Pocket Maximum (“OOPM”)	\$1,500	\$1,500	\$3,000

Cost Share Summary Tables by Benefit

How to read the Cost Share summary tables

Each table below explains the Cost Share for a category of benefits. Specific Services related to the benefit are described in the first column of each table. For a detailed description of coverage for a particular benefit, please refer to the same benefit heading in the “Benefits” section of this *EOC*.

- **Copayment / Coinsurance.** This column describes the Cost Share you will pay for Services after you have met your Plan Deductible or Drug Deductible, if applicable. (Please see the “Deductible(s) and Out-of-Pocket Maximum(s)” section above to determine if your plan includes deductibles.) If the Services are not covered in your plan, this column will read “Not covered.” If we provide an Allowance that you can use toward the cost of the Services, this column will include the Allowance.
- **Subject to Deductible.** This column explains whether the Cost Share you pay for Services is subject to a Plan Deductible or Drug Deductible. If the Services are subject to a deductible, you will pay Charges for those Services until you have met your deductible. If the Services are subject to a deductible, there will be a “✓” or “●” in this column, depending on which deductible applies (“✓” for Plan Deductible, “●” for Drug Deductible). If the Services do not apply to a deductible, or if your plan does not include a deductible, this column will be blank. For a more detailed explanation of deductibles, please refer to “Plan Deductible” and “Drug Deductible” in the “Benefits” section of this *EOC*.
- **OOPM.** This column explains whether the Cost Share you pay for Services counts toward the Plan Out-of-Pocket Maximum (“OOPM”) after you have met any applicable deductible. If the Services count toward the Plan OOPM, there will be a “✓” in this column. If the Services do not count toward the Plan OOPM, this column will be blank. For a more detailed explanation of the Plan OOPM, please refer to “Plan Out-of-Pocket Maximum” heading in the “Benefits” section of this *EOC*.

Administered drugs and products

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Whole blood, red blood cells, plasma, and platelets	No charge		✓
Allergy antigens (including administration)	\$3 per visit		✓
Cancer chemotherapy drugs and adjuncts	No charge		✓
Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products (“biologics”) derived from tissue, cells, or blood	No charge		✓
All other administered drugs and products	No charge		✓
Drugs and products administered to you during a home visit	No charge		✓

Ambulance Services

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Emergency ambulance Services	\$50 per trip		✓
Nonemergency ambulance and psychiatric transport van Services	\$50 per trip		✓

Behavioral health treatment for pervasive development disorder or autism

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Covered Services	\$15 per day		✓

Dialysis care

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Equipment and supplies for home hemodialysis and home peritoneal dialysis	No charge		✓
One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment	No charge		✓

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Hemodialysis and peritoneal dialysis treatment at a Plan Facility	\$15 per visit		✓

Durable Medical Equipment (“DME”) for home use

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Blood glucose monitors for diabetes blood testing and their supplies	20% Coinsurance		✓
Peak flow meters	20% Coinsurance		✓
Insulin pumps and supplies to operate the pump	20% Coinsurance		✓
Other Base DME Items as described in this <i>EOC</i>	20% Coinsurance		✓
Supplemental DME items as described in this <i>EOC</i>	20% Coinsurance		
Retail-grade breast pumps	No charge		✓
Hospital-grade breast pumps	No charge		✓

Emergency and Urgent Care visits

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Emergency Department visits	\$50 per visit		✓
Urgent Care visits	\$15 per visit		✓

Note: If you are admitted to the hospital as an inpatient from the Emergency Department, the Emergency Department visits Cost Share above does not apply. Instead, the Services you received in the Emergency Department, including any observation stay, if applicable, will be considered part of your inpatient hospital stay. For the Cost Share for inpatient care, please refer to “Hospital inpatient care” in this “Cost Share Summary.” The Emergency Department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient.

Family planning Services

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Family planning counseling	No charge		✓

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices (“IUDs”) and office visits related to their administration and management	No charge		✓
Female sterilization procedures if performed in an ambulatory surgery center or in a hospital operating room	No charge		✓
All other female sterilization procedures	No charge		✓
Male sterilization procedures if performed in an ambulatory surgery center or in a hospital operating room	\$15 per procedure		✓
All other male sterilization procedures	\$15 per visit		✓
Termination of pregnancy	\$15 per procedure		✓

Fertility Services

Diagnosis and treatment of infertility

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Office visits	\$15 per visit		
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	\$15 per procedure		
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	\$15 per procedure		
Outpatient imaging	\$5 per encounter		
Outpatient laboratory	\$5 per encounter		
Outpatient diagnostic Services	\$5 per encounter		
Outpatient administered drugs	No charge		

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Hospital inpatient care (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	No charge		

Artificial insemination

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Office visits	\$15 per visit		
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	\$15 per procedure		
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	\$15 per procedure		
Outpatient imaging	\$5 per encounter		
Outpatient laboratory	\$5 per encounter		
Outpatient diagnostic Services	\$5 per encounter		
Outpatient administered drugs	No charge		
Hospital inpatient care (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	No charge		

Assisted reproductive technology (“ART”) Services

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Assisted reproductive technology (“ART”) Services such as invitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), or zygote intrafallopian transfer (“ZIFT”)	Not covered		

Health education

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Covered health education programs, which may include programs provided online and counseling over the phone	No charge		✓
Individual counseling during an office visit related to smoking cessation	No charge		✓
Individual counseling during an office visit related to diabetes management	No charge		✓
Other covered individual counseling when the office visit is solely for health education	No charge		✓
Covered health education materials	No charge		✓

Hearing Services

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Hearing exams with an audiologist to determine the need for hearing correction	\$15 per visit		✓
Physician Specialist Visits to diagnose and treat hearing problems	\$15 per visit		✓
Hearing aid(s), including, fitting, counseling, adjustment, cleaning, and inspection	Not covered		

Home health care

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Home health care Services (100 visits per Accumulation Period)	No charge		✓

Hospice care

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Hospice Services	No charge		✓

Hospital inpatient care

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Inpatient hospital stays	No charge		✓

Injury to teeth

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Accidental injury to teeth	Not covered		

Mental health Services

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Inpatient mental health hospital stays	No charge		✓
Individual mental health evaluation and treatment	\$15 per visit		✓
Group mental health treatment	\$7 per visit		✓
Partial hospitalization	No charge		✓
Other intensive psychiatric treatment programs	No charge		✓
Residential mental health treatment Services	No charge		✓

Office visits

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this “Cost Share Summary”	\$15 per visit		✓
Physician Specialist Visits that are not described elsewhere in this “Cost Share Summary”	\$15 per visit		✓
Group appointments that are not described elsewhere in this “Cost Share Summary”	\$7 per visit		✓

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Acupuncture Services	\$15 per visit		✓
House calls	No charge		✓

Ostomy and urological supplies

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Ostomy and urological supplies as described in this <i>EOC</i>	No charge		✓

Outpatient imaging, laboratory, and other diagnostic and treatment Services

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans	No charge		✓
Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds	No charge		✓
Nuclear medicine	No charge		✓
Routine retinal photography screenings	No charge		✓
Routine laboratory tests to monitor the effectiveness of dialysis	No charge		✓
All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available)	No charge		✓
Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs)	No charge		✓
Radiation therapy	No charge		✓
Ultraviolet light treatments	No charge		✓

Outpatient prescription drugs, supplies, and supplements

If the “Cost Share at a Plan Pharmacy” column in this section provides Cost Share for a 30-day supply and your Plan Physician prescribes more than this, you may be able to obtain more than a 30-day supply at one time up to the day supply

limit for that drug. Applicable Cost Share will apply. For example, two 30-day copayments may be due when picking up a 60-day prescription, three copayments may be due when picking up a 100-day prescription at the pharmacy.

Most items

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
Items on the generic tier not described elsewhere in this “Cost Share Summary”	\$10 for up to a 100-day supply	\$10 for up to a 100-day supply		✓
Items on the brand tier not described elsewhere in this “Cost Share Summary”	\$20 for up to a 100-day supply	\$20 for up to a 100-day supply		✓
Items on the specialty tier not described elsewhere in this “Cost Share Summary”	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Base drugs, supplies, and supplements

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
Hematopoietic agents for dialysis	No charge for up to a 30-day supply	Not available		✓
Elemental dietary enteral formula when used as a primary therapy for regional enteritis	No charge for up to a 30-day supply	Not available		✓
All other items on the generic tier as described in this <i>EOC</i>	\$10 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
All other items on the brand tier as described in this <i>EOC</i>	\$20 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
All other items on the specialty tier as described in this <i>EOC</i>	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Anticancer drugs and certain critical adjuncts following a diagnosis of cancer

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
Oral anticancer drugs on the generic tier	\$10 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on the brand tier	\$20 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on the specialty tier	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on the generic tier	\$10 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on the brand tier	\$20 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on the specialty tier	\$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Home infusion drugs

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
Home infusion drugs	No charge for up to a 30-day supply	Not available		✓
Supplies necessary for administration of home infusion drugs	No charge	No charge		✓

Home infusion drugs are self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion, such as an intravenous or intraspinal-infusion.

Diabetes supplies and amino acid–modified products

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)	No charge for up to a 30-day supply	Not available		✓
Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing	No charge for up to a 100-day supply	Not available		✓
Insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear)	\$10 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

For drugs related to the treatment of diabetes (for example, insulin), and for continuous insulin delivery devices that use disposable items such as patches or pods, please refer to the “Most items” table above. For insulin pumps, please refer to the “Durable Medical Equipment (“DME”) for home use” table above.

Contraceptive drugs and devices

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
The following hormonal contraceptive items for women on the generic tier when prescribed by a Plan Provider: <ul style="list-style-type: none"> • Rings • Patches • Oral contraceptives 	No charge for up to a 365-day supply	No charge for up to a 365-day supply Rings are not available for mail order		✓
The following contraceptive items for women on the generic tier when prescribed by a Plan Provider: <ul style="list-style-type: none"> • Female condoms • Spermicide • Sponges 	No charge for up to a 100-day supply	Not available		✓
The following hormonal contraceptive items for women on the brand tier when prescribed by a Plan Provider: <ul style="list-style-type: none"> • Rings • Patches • Oral contraceptives 	No charge for up to a 365-day supply	No charge for up to a 365-day supply Rings are not available for mail order		✓

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
The following contraceptive items for women on the brand tier when prescribed by a Plan Provider: <ul style="list-style-type: none"> • Female condoms • Spermicide • Sponges 	No charge for up to a 100-day supply	Not available		✓
Emergency contraception	No charge	Not available		✓
Diaphragms and cervical caps	No charge	Not available		✓

Certain preventive items

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
Items on our Preventive Services list on our website at kp.org/prevention when prescribed by a Plan Provider	No charge for up to a 100-day supply	Not available		✓

Fertility and sexual dysfunction drugs

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
Drugs on the generic tier prescribed to treat infertility or in connection with covered artificial insemination Services	\$10 for up to a 100-day supply	\$10 for up to a 100-day supply		
Drugs on the brand and specialty tiers prescribed to treat infertility or in connection with covered artificial insemination Services	\$20 for up to a 100-day supply	\$20 for up to a 100-day supply		
Drugs on the generic tier prescribed in connection with covered assisted reproductive technology (“ART”) Services	Not covered	Not covered		
Drugs on the brand and specialty tiers prescribed in connection with covered assisted reproductive technology (“ART”) Services	Not covered	Not covered		

Description	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	OOPM
Drugs on the generic tier prescribed for sexual dysfunction disorders	50% Coinsurance (not to exceed \$50) for up to a 100-day supply	50% Coinsurance (not to exceed \$50) for up to a 100-day supply		✓
Drugs on the brand and specialty tiers prescribed for sexual dysfunction disorders	50% Coinsurance (not to exceed \$100) for up to a 100-day supply	50% Coinsurance (not to exceed \$100) for up to a 100-day supply		✓

Outpatient surgery and outpatient procedures

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when provided in an ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	\$15 per procedure		✓
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	\$15 per procedure		✓

Preventive Services

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Routine physical exams, including well-woman and preventive exams for Members age 2 and older	No charge		✓
Well-child preventive exams for Members through age 23 months	No charge		✓
Normal series of regularly scheduled preventive prenatal care exams after confirmation of pregnancy	No charge		✓
First postpartum follow-up consultation and exam	No charge		✓
Immunizations (including the vaccine) administered to you in a Plan Medical Office	No charge		✓
Tuberculosis skin tests	No charge		✓

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Screening and counseling Services when provided during a routine physical exam or a well-child preventive exam, such as obesity counseling, routine vision and hearing screenings, alcohol and substance abuse screenings, health education, depression screening, and developmental screenings to diagnose and assess potential developmental delays	No charge		✓
Screening colonoscopies	No charge		✓
Screening flexible sigmoidoscopies	No charge		✓
Routine imaging screenings such as mammograms	No charge		✓
Bone density CT scans	No charge		✓
Bone density DEXA scans	No charge		✓
Routine laboratory tests and screenings, such as cancer screening tests, sexually transmitted infection (“STI”) tests, cholesterol screening tests, and glucose tolerance tests	No charge		✓
Other laboratory screening tests, such as fecal occult blood tests and hepatitis B screening tests	No charge		✓

Prosthetic and orthotic devices

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Internally implanted prosthetic and orthotic devices as described in this <i>EOC</i>	No charge		✓
External prosthetic and orthotic devices as described in this <i>EOC</i>	No charge		✓
Supplemental prosthetic and orthotic devices as described in this <i>EOC</i>	No charge		✓

Rehabilitative and habilitative Services

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Individual outpatient physical, occupational, and speech therapy	\$15 per visit		✓
Group outpatient physical, occupational, and speech therapy	\$7 per visit		✓
Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program	\$15 per day		✓

Skilled nursing facility care

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Skilled nursing facility Services up to 100 days per benefit period*	No charge		✓

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

Substance use disorder treatment

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Inpatient detoxification	No charge		✓
Individual substance use disorder evaluation and treatment	\$15 per visit		✓
Group substance use disorder treatment	\$5 per visit		✓
Intensive outpatient and day-treatment programs	\$5 per day		✓
Residential substance use disorder treatment	No charge		✓

Telehealth visits

Interactive video visits

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge		✓

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Physician Specialist Visits	No charge		✓

Scheduled telephone visits

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge		✓
Physician Specialist Visits	No charge		✓

Vision Services for Adult Members

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	\$15 per visit		✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	\$15 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Low vision devices (including fitting and dispensing)	Not covered		

Vision Services for Pediatric Members

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	\$15 per visit		✓

Description of Services	Copayment / Coinsurance	Subject to Deductible	OOPM
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	\$15 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Low vision devices (including fitting and dispensing)	Not covered		

Introduction

This *Evidence of Coverage* (“*EOC*”) describes the health care coverage of “Kaiser Permanente Traditional HMO Plan” provided under the *Group Agreement* (“*Agreement*”) between Kaiser Foundation Health Plan, Inc. (“Health Plan”) and the entity with which Health Plan has entered into the *Agreement* (your “Group”).

This *EOC* is part of the *Agreement* between Health Plan and your Group. The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

Once enrolled in other coverage made available through Health Plan, that other plan’s evidence of coverage cannot be cancelled without cancelling coverage under this *EOC*, unless the change is made during open enrollment or a special enrollment period.

For benefits provided under any other program offered by your Group (for example, workers compensation benefits), refer to your Group’s materials.

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

It is important to familiarize yourself with your coverage by reading this *EOC* completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

About Kaiser Permanente

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY GET HEALTH CARE.

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), which we call your “Home Region.” The

coverage information in this *EOC* applies when you obtain care in your Home Region. When you visit the other California Region, you may receive care as described in “Receiving Care Outside of Your Home Region” in the “How to Obtain Services” section.

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

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

- Authorized referrals as described under “Getting a Referral” in the “How to Obtain Services” section
- Emergency ambulance Services as described under “Ambulance Services” in the “Benefits” 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” section
- Visiting Member Services as described under “Receiving Care Outside of Your Home Region” in the “How to Obtain Services” section

Term of this EOC

This *EOC* is for the period January 1, 2021, through December 31, 2021, unless amended. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended.

Definitions

Some terms have special meaning in this *EOC*. When we use a term with special meaning in only one section of this *EOC*, we define it in that section. The terms in this “Definitions” section have special meaning when capitalized and used in any section of this *EOC*.

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable), out-of-pocket maximums, and benefit limits. For example, the Accumulation Period may be a calendar year or contract year. The Accumulation Period for this *EOC* is from January 1 through December 31.

Adult Member: A Member who is age 19 or older and is not a Pediatric Member. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1.

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

Ancillary Coverage: Optional benefits such as acupuncture, chiropractic, or dental coverage that may be available to Members enrolled under this *EOC*. If your plan includes Ancillary Coverage, this coverage will be described in an amendment to this *EOC* or a separate agreement from the issuer of the coverage.

Charges: “Charges” means the following:

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

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service under this *EOC*.

Copayment: A specific dollar amount that you must pay when you receive a covered Service under this *EOC*.

Note: The dollar amount of the Copayment can be \$0 (no charge).

Cost Share: The amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

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

Disclosure Form (“DF”): A summary of coverage for prospective Members. For some products, the DF is combined with the evidence of coverage.

Drug Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain drugs, supplies, and supplements before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Please refer to the “Cost Share Summary” section to learn whether your coverage includes a Drug Deductible, the Services that are subject to the Drug Deductible, and the Drug Deductible amount.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that you reasonably believed that the absence of immediate medical attention would result in any of the following:

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

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

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

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

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

EOC: This *Evidence of Coverage* document, including any amendments, which describes the health care coverage of “Kaiser Permanente Traditional HMO Plan” under Health Plan’s *Agreement* with your Group.

Family: A Subscriber and all of their Dependents.

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

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. Health Plan is a health care service plan licensed to offer health care coverage by the Department of Managed Health Care. This *EOC* sometimes refers to Health Plan as “we” or “us.”

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

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

Medical Group: The Southern California Permanente Medical Group, a for-profit professional partnership.

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

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

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

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists). For Services described under “Dental and Orthodontic Services” in the “Benefits” section, non-physician specialists include dentists and orthodontists.

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

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

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

Non-Plan Psychiatrist: A psychiatrist who is not a Plan Physician.

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

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

Pediatric Member: A Member from birth through the end of the month of their 19th birthday. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1 and your last minute as a Pediatric Member will be 11:59 p.m. on June 30.

Physician Specialist Visits: Consultations, evaluations, and treatment by physician specialists, including personal Plan Physicians who are not Primary Care Physicians.

Plan Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Please refer to the “Cost Share Summary” section to learn whether your coverage includes a Plan Deductible, the Services that are subject to the Plan Deductible, and the Plan Deductible amount.

Plan Facility: Any facility listed in the Provider Directory on our website at kp.org/facilities. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

Plan Hospital: Any hospital listed in the Provider Directory on our website at kp.org/facilities. In the directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call our Member Service Contact Center.

Plan Medical Office: Any medical office listed in the Provider Directory on our website at kp.org/facilities. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The directory is updated periodically. The availability of Plan Medical Offices may change. If you have questions, please call our Member Service Contact Center.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Refer to the Provider Directory on our website at kp.org/facilities for locations of Plan Optical Sales Offices. In the directory, Plan Optical Sales Offices may be called “Vision Essentials.” The directory is updated periodically. The availability of Plan Optical Sales Offices may change. If you have questions, please call our Member Service Contact Center.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for certain covered Services that you receive in the same Accumulation Period. Please refer to the “Cost Share Summary” section to find your Plan Out-of-Pocket Maximum amount and to learn which Services apply to the Plan Out-of-Pocket Maximum.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the Provider Directory on our website at kp.org/facilities for locations of Plan Pharmacies. The directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call our Member Service Contact Center.

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

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

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

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that this condition is Stabilized.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *EOC*, except that you are responsible for paying Premiums if you have Cal-COBRA coverage. “Full Premiums” means 100 percent of Premiums for all of the coverage issued to each enrolled Member, as set forth in the “Premiums” section of Health Plan’s *Agreement* with your Group.

Preventive Services: Covered Services that prevent or detect illness and do one or more of the following:

- Protect against disease and disability or further progression of a disease
- Detect disease in its earliest stages before noticeable symptoms develop

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Refer to the Provider Directory on our website at kp.org for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call our Member Service Contact Center.

Primary Care Visits: Evaluations and treatment provided by Primary Care Physicians and primary care Plan Providers who are not physicians (such as nurse practitioners).

Provider Directory: A directory of Plan Physicians and Plan Facilities in your Home Region. This directory is available on our website at kp.org/facilities. To obtain a printed copy, call our Member Service Contact Center. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently the District of Columbia and parts of Northern California, Southern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at kp.org or call our Member Service Contact Center.

Serious Emotional Disturbance of a Child Under Age 18: A condition identified as a “mental disorder” in the

most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:

- As a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
- The child displays psychotic features, or risk of suicide or violence due to a mental disorder
- The child meets special education eligibility requirements under Section 5600.3(a)(2)(C) of the Welfare and Institutions Code

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

- The following ZIP codes in Imperial County are inside our Service Area: 92274-75
- The following ZIP codes in Kern County are inside our Service Area: 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380, 93383-90, 93501-02, 93504-05, 93518-19, 93531, 93536, 93560-61, 93581
- The following ZIP codes in Los Angeles County are inside our Service Area: 90001-84, 90086-91, 90093-96, 90099, 90134, 90189, 90201-02, 90209-13, 90220-24, 90230-33, 90239-42, 90245, 90247-51, 90254-55, 90260-67, 90270, 90272, 90274-75, 90277-78, 90280, 90290-96, 90301-12, 90401-11, 90501-10, 90601-10, 90623, 90630-31, 90637-40, 90650-52, 90660-62, 90670-71, 90701-03, 90706-07, 90710-17, 90723, 90731-34, 90744-49, 90755, 90801-10, 90813-15, 90822, 90831-35, 90840, 90842, 90844, 90846-48, 90853, 90895, 90899, 91001, 91003, 91006-12, 91016-17, 91020-21, 91023-25, 91030-31, 91040-43, 91046, 91066, 91077, 91101-10, 91114-18, 91121, 91123-26, 91129, 91182, 91184-85, 91188-89, 91199, 91201-10, 91214, 91221-22, 91224-26, 91301-11, 91313, 91316, 91321-22, 91324-31, 91333-35, 91337, 91340-46, 91350-57, 91361-62, 91364-65, 91367, 91371-72, 91376, 91380-87, 91390, 91392-96, 91401-13, 91416, 91423, 91426, 91436, 91470, 91482, 91495-96, 91499, 91501-08, 91510, 91521-23, 91526, 91601-12, 91614-18, 91702, 91706,

91711, 91714-16, 91722-24, 91731-35, 91740-41, 91744-50, 91754-56, 91759, 91765-73, 91775-76, 91778, 91780, 91788-93, 91801-04, 91896, 91899, 93243, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93560, 93563, 93584, 93586, 93590-91, 93599

- All ZIP codes in Orange County are inside our Service Area: 90620-24, 90630-33, 90638, 90680, 90720-21, 90740, 90742-43, 92602-07, 92609-10, 92612, 92614-20, 92623-30, 92637, 92646-63, 92672-79, 92683-85, 92688, 92690-94, 92697-98, 92701-08, 92711-12, 92728, 92735, 92780-82, 92799, 92801-09, 92811-12, 92814-17, 92821-23, 92825, 92831-38, 92840-46, 92850, 92856-57, 92859, 92861-71, 92885-87, 92899
- The following ZIP codes in Riverside County are inside our Service Area: 91752, 92028, 92201-03, 92210-11, 92220, 92223, 92230, 92234-36, 92240-41, 92247-48, 92253-55, 92258, 92260-64, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501-09, 92513-14, 92516-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92589-93, 92595-96, 92599, 92860, 92877-83
- The following ZIP codes in San Bernardino County are inside our Service Area: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91766, 91784-86, 91792, 92252, 92256, 92268, 92277-78, 92284-86, 92305, 92307-08, 92313-18, 92321-22, 92324-25, 92329, 92331, 92333-37, 92339-41, 92344-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-95, 92397, 92399, 92401-08, 92410-11, 92413, 92415, 92418, 92423, 92427, 92880
- The following ZIP codes in San Diego County are inside our Service Area: 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-46, 91950-51, 91962-63, 91976-80, 91987, 92003, 92007-11, 92013-14, 92018-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-61, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-86, 92088, 92091-93, 92096, 92101-24, 92126-32, 92134-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-61, 92163, 92165-79, 92182, 92186-87, 92191-93, 92195-99
- The following ZIP codes in Tulare County are inside our Service Area: 93238, 93261
- The following ZIP codes in Ventura County are inside our Service Area: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07, 93009-12, 93015-16, 93020-22, 93030-36, 93040-44, 93060-66, 93094, 93099, 93252

For each ZIP code listed for a county, our Service Area includes only the part of that ZIP code that is in that

county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside our Service Area unless that other county is listed above and that ZIP code is also listed for that other county.

If you have a question about whether a ZIP code is in our Service Area, please call our Member Service Contact Center.

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

Services: Health care services or items (“health care” includes both physical health care and mental health care), behavioral health treatment covered under “Behavioral Health Treatment for Pervasive Developmental Disorder or Autism” in the “Benefits” section, and services to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness.

Severe Mental Illness: The following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa.

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

Spouse: The person to whom the Subscriber is legally married under applicable law. For the purposes of this *EOC*, the term “Spouse” includes the Subscriber’s domestic partner. “Domestic partners” are two people who are registered and legally recognized as domestic partners by California (if your Group allows enrollment of domestic partners not legally recognized as domestic partners by California, “Spouse” also includes the Subscriber’s domestic partner who meets your Group’s eligibility requirements for domestic partners).

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

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

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

Telehealth Visits: Interactive video visits and scheduled telephone visits between you and your provider.

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

Premiums, Eligibility, and Enrollment

Premiums

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

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this “Who Is Eligible” section, including your Group’s eligibility requirements and our Service Area eligibility requirements.

Group eligibility requirements

You must meet your Group’s eligibility requirements, such as the minimum number of hours that employees must work. Your Group is required to inform Subscribers of its eligibility requirements.

Service Area eligibility requirements

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

Subscribers must live or work inside our Service Area at the time they enroll. If after enrollment the Subscriber no longer lives or works inside our Service Area, the Subscriber can continue membership unless (1) they live inside or move to the service area of another Region and do not work inside our Service Area, or (2) your Group does not allow continued enrollment of Subscribers who do not live or work inside our Service Area.

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

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

- **Regions outside California.** You may be able to enroll in the service area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*
- **Northern California Region's service area.** Your Group may have an arrangement with us that permits membership in the Northern California Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*. All terms and conditions in your application for enrollment in the Southern California Region, including the Arbitration Agreement, will continue to apply if the Subscriber does not submit a new enrollment form

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

Eligibility as a Subscriber

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

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

Eligibility as a Dependent

Enrolling a Dependent

Dependent eligibility is subject to your Group's eligibility requirements, which are not described in this *EOC*. You can obtain your Group's eligibility requirements directly from your Group. If you are a Subscriber under this *EOC* and if your Group allows enrollment of Dependents, Health Plan allows the following persons to enroll as your Dependents under this *EOC*:

- Your Spouse
- Your or your Spouse's Dependent children, who meet the requirements described under "Age limit of Dependent children," if they are any of the following:
 - ◆ sons, daughters, or stepchildren
 - ◆ adopted children
 - ◆ children placed with you for adoption, but not including children placed with you for foster care
 - ◆ children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)
- Children whose parent is a Dependent under your family coverage (including adopted children and children placed with your Dependent for adoption, but not including children placed with your Dependent for foster care) if they meet all of the following requirements:
 - ◆ they are not married and do not have a domestic partner (for the purposes of this requirement only, "domestic partner" means someone who is registered and legally recognized as a domestic partner by California)
 - ◆ they meet the requirements described under "Age limit of Dependent children"
 - ◆ they receive all of their support and maintenance from you or your Spouse
 - ◆ they permanently reside with you or your Spouse

If you have a baby

If you have a baby while enrolled under this *EOC*, the baby is not automatically enrolled in this plan. The Subscriber must request enrollment of the baby as described under "Special enrollment" in the "How to Enroll and When Coverage Begins" section below. If the Subscriber does not request enrollment within this special enrollment period, the baby will only be covered under this plan for 31 days (including the date of birth), or until the date the baby is enrolled in other coverage, whichever happens first.

Age limit of Dependent children

Children must be under age 26 as of the effective date to enroll as a Dependent under your plan.

Dependent children are eligible to remain on the plan through the end of the month in which they reach the age limit.

Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption, but not including children placed with you for foster care) who reach the age limit may continue coverage under this *EOC* if all of the following conditions are met:

- They meet all requirements to be a Dependent except for the age limit
- Your Group permits enrollment of Dependents
- They are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
- They receive 50 percent or more of their support and maintenance from you or your Spouse
- You give us proof of their incapacity and dependency within 60 days after we request it (see “Disabled Dependent certification” below in this “Eligibility as a Dependent” section)

Disabled Dependent certification

One of the requirements for a Dependent to be eligible to continue coverage as a disabled Dependent is that the Subscriber must provide us documentation of the dependent’s incapacity and dependency as follows:

- If the child is a Member, we will send the Subscriber a notice of the Dependent’s membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent’s membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent’s incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as a disabled dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that the Dependent does not meet the eligibility requirements as a disabled dependent, we will notify the Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If we determine that the Dependent is eligible as a disabled dependent, there will be no lapse in

coverage. Also, starting two years after the date that the Dependent reached the age limit, the Subscriber must provide us documentation of the Dependent’s incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as a disabled dependent

- If the child is not a Member because you are changing coverage, you must give us proof, within 60 days after we request it, of the child’s incapacity and dependency as well as proof of the child’s coverage under your prior coverage. In the future, you must provide proof of the child’s continued incapacity and dependency within 60 days after you receive our request, but not more frequently than annually

If the Subscriber is enrolled under a Kaiser Permanente Medicare plan

The dependent eligibility rules described in the “Eligibility as a Dependent” section also apply if you are a subscriber under a Kaiser Permanente Medicare plan offered by your Group (please ask your Group about your membership options). 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.

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 *EOC* is not intended for most Medicare beneficiaries and some Groups do not offer coverage to retirees. If, during the term of this *EOC*, you are (or become) 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 *EOC* 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 *EOC* 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).

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 *EOC* 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 spouse 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 *EOC* is creditable prescription drug coverage at the times required by the Centers for Medicare & Medicaid Services and upon your request.

How to 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, which allow enrollment in other situations.

If you are eligible to be a Dependent under this *EOC* but the subscriber in your family is enrolled under a Kaiser Permanente Senior Advantage evidence of coverage offered by your Group, the rules for enrollment of Dependents in this “How to 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 in accord with waiting period requirements in state and federal law. Your Group is required to inform the Subscriber of the date your membership becomes effective. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: If the effective date of your Group’s coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

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 because you experience a qualifying event (sometimes called a “triggering event”) 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, date of adoption, or the date you or your Spouse have newly assumed a legal right to control health care in anticipation of 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 they 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 coverage through Covered California, Medicaid coverage (known as Medi-Cal in California), Children’s Health Insurance Program coverage, or Medi-Cal Access 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 coverage through Covered California, Medicaid, Children’s Health Insurance Program, or Medi-Cal Access 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 30 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.

The effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than 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 30 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.

Other special enrollment events

You may enroll as a Subscriber (along with any eligible Dependents) if you or your Dependents were not previously enrolled, and existing Subscribers may add eligible Dependents not previously enrolled, if any of the following are true:

- You lose employment for a reason other than gross misconduct
- Your employment hours are reduced
- You are a Dependent of someone who becomes entitled to Medicare
- You become divorced or legally separated
- You are a Dependent of someone who dies
- A Health Benefit Exchange (such as Covered California) determines that one of the following occurred because of misconduct on the part of a non-Exchange entity that provided enrollment assistance or conducted enrollment activities:
 - ◆ a qualified individual was not enrolled in a qualified health plan
 - ◆ a qualified individual was not enrolled in the qualified health plan that the individual selected
 - ◆ a qualified individual is eligible for, but is not receiving, advance payments of the premium tax credit or cost share reductions

To request special enrollment, you must submit a Health Plan-approved enrollment application to your Group within 30 days after loss of other coverage. You may be required to provide documentation that you have experienced a qualifying event. Membership becomes effective either on the first day of the next month (for applications that are received by the fifteenth day of a month) or on the first day of the month following the next month (for applications that are received after the fifteenth day of a month).

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

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" 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" section
- Visiting Member Services as described under "Receiving Care Outside of Your Home Region" in this "How to Obtain Services" section

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

Routine Care

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

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

To request a non-urgent appointment, you can call your local Plan Facility or request the appointment online. For appointment phone numbers, please refer to our Provider Directory or call our Member Service Contact Center. To request an appointment online, go to our website at kp.org.

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 phone number at a Plan Facility. For phone numbers, please refer to our Provider Directory or call our Member Service Contact Center.

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 or you are outside our Service Area

You can reach one of these licensed health care professionals by calling the appointment or advice phone number (for phone numbers, refer to our Provider Directory or call our Member Service Contact Center). 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. However, if you choose a specialist who is not designated as a Primary Care Physician as your personal Plan Physician, the Cost Share for a Physician Specialist Visit will apply to all visits with the specialist except for routine preventive visits listed under “Preventive Services” in the “Benefits” section.

To learn how to select or change to a different personal Plan Physician, visit our website at kp.org or call our Member Service Contact Center. Refer to our Provider Directory for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call our Member Service Contact Center. You can change your personal Plan Physician at any time 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, dermatology, and physical, occupational, and speech therapies. Also, a Plan Physician must refer you before you can get care from Qualified Autism Service Providers covered under “Behavioral Health Treatment for Pervasive Developmental Disorder or Autism” in the “Benefits” section. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, mental health Services, substance use disorder treatment, and obstetrics/gynecology

A Plan Physician must refer you before you can get care from a specialist in urology except that you do not need a

referral to receive Services related to sexual or reproductive health, such as a vasectomy.

Although a referral or prior authorization is not required to receive most care from these providers, a referral may be required in the following situations:

- 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
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

If a Plan Physician refers you to a specialist, the referral will be for a specific treatment plan. Your treatment plan may include a standing referral if ongoing care from the specialist is prescribed. For example, if you have a life-threatening, degenerative, or disabling condition, you can get a standing referral to a specialist if ongoing care from the specialist is required.

Medical Group authorization procedure for certain referrals

The following are examples of Services that 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
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management (“UM”) is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at kp.org/UM or call our Member Service Contact Center to request a printed copy.

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.

Additional information about prior authorization for durable medical equipment and ostomy and urological supplies

The prior authorization process for durable medical equipment and ostomy and urological supplies includes the use of formulary guidelines. These guidelines were developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with clinical expertise. The formulary guidelines are periodically updated to keep pace with changes in medical technology and clinical practice.

If your Plan Physician prescribes one of these items, they will submit a written referral in accord with the UM process described in this “Medical Group authorization procedure for certain referrals” section. If the formulary guidelines do not specify that the prescribed item is appropriate for your medical condition, the referral will be submitted to the Medical Group’s designee Plan Physician, who will make an authorization decision as described under “Medical Group’s decision time frames” in this “Medical Group authorization procedure for certain referrals” section.

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. 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.

If the Medical Group does not authorize all of the Services requested and you want to appeal the decision, you can file a grievance as described under “Grievances” in the “Dispute Resolution” section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Travel and lodging for certain referrals

The following are examples of when we will arrange or provide reimbursement for certain travel and lodging expenses in accord with our Travel and Lodging Program Description:

- If Medical Group refers you to a provider that is more than 50 miles from where you live for certain specialty Services such as bariatric surgery, complex thoracic surgery, transplant nephrectomy, or inpatient chemotherapy for leukemia and lymphoma
- If Medical Group refers you to a provider that is outside our Service Area for certain specialty Services such as a transplant or transgender surgery

For the complete list of specialty Services for which we will arrange or provide reimbursement for travel and lodging expenses, the amount of reimbursement, limitations and exclusions, and how to request reimbursement, please refer to the Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at kp.org/specialty-care/travel-reimbursements or by calling our Member Service Contact Center.

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
- 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
- Mental health conditions in pregnant Members that occur, or can impact the Member, during pregnancy or during the postpartum period including, but not limited to, postpartum depression. We may cover completion of these Services for up to 12 months from the mental health diagnosis or from the end of pregnancy, whichever occurs later
- 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
- 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 Services
- 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 requirement that the provider agree to providing Services inside our Service Area doesn't apply if you were receiving covered Services from the provider outside the Service Area when the provider's contract terminated)
- The Services to be provided to you would be covered Services under this *EOC* 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

For completion of Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

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 Contact Center.

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an appropriately qualified medical professional for your condition. If there isn't a Plan Physician who is

an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with a Non-Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within their scope of practice and who possesses a clinical background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion.

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

- 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

An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial and of your right to file a grievance as described under "Grievances" in the "Dispute Resolution" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

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 visit our website at **kp.org** or call our Member Service Contact Center.

Financial liability

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

When you are referred to a Plan Provider for covered Services, you pay the Cost Share required for Services from that provider as described in this *EOC*.

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 the covered Services 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).

Receiving Care Outside of Your Home Region

If you have questions about your coverage when you are away from home, call the Away from Home Travel line at **1-951-268-3900** 24 hours a day, seven days a week (except closed holidays). For example, call this number for the following concerns:

- What you should do to prepare for your trip
- What Services are covered when you are outside our Service Area
- How to get care in another Region
- How to request reimbursement if you paid for covered Services outside our Service Area

You can also get information on our website at kp.org/travel.

Receiving care in the Service Area of another Region

If you are visiting in the service area of another Region, you may receive Visiting Member Services from designated providers in that Region. "Visiting Member Services" are Services that are covered under your Home

Region plan that you receive in another Region, subject to exclusions, limitations, prior authorization or approval requirements, and reductions described in this *EOC* or the Visiting Member Brochure, which is available online at kp.org. Certain Services are not covered as Visiting Member Services. For more information about receiving Visiting Member Services in another Region, including provider and facility locations, or to obtain a copy of the Visiting Member Brochure, please call our Away from Home Travel Line at **1-951-268-3900** 24 hours a day, seven days a week (except closed holidays). Information is also available online at kp.org/travel.

For Visiting Member Services, you pay the Cost Share required for Services provided by a Plan Provider inside our Service Area as described in this *EOC*.

Receiving care outside of any Region

If you are traveling outside of a Kaiser Permanente Region, we cover Emergency Services and Urgent Care as described in the "Emergency Services and Urgent Care" section.

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 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 Contact Center if we ever inadvertently issue you more than one medical record number or if you need to replace your 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 they receive. 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.

Timely Access to Care

Standards for appointment availability

The California Department of Managed Health Care ("DMHC") developed the following standards for appointment availability. This information can help you know what to expect when you request an appointment.

- Urgent Care: within 48 hours

- Nonurgent Primary Care Visit or Non-Physician Specialist Visit: within 10 business days
- Physician Specialist Visit: within 15 business days

If you prefer to wait for a later appointment that will better fit your schedule or to see the Plan Provider of your choice, we will respect your preference. In some cases, your wait may be longer than the time listed if a licensed health care professional decides that a later appointment won't have a negative effect on your health.

The standards for appointment availability do not apply to Preventive Services. Your Plan Provider may recommend a specific schedule for Preventive Services, depending on your needs. The standards also do not apply to periodic follow-up care for ongoing conditions or standing referrals to specialists.

Timely access to telephone assistance

DMHC developed the following standards for answering telephone questions:

- For telephone advice about whether you need to get care and where to get care: within 30 minutes, 24 hours a day, 7 days a week
- For general questions: within 10 minutes during normal business hours

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call our Member Service Contact Center.

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

Member Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain the following:

- Your Health Plan benefits
- How to make your first medical appointment
- What to do if you move

- How to replace your Kaiser Permanente ID card

You can reach Member Services in the following ways:

Call **1-800-464-4000** (English and more than 150 languages using interpreter services)
1-800-788-0616 (Spanish)
1-800-757-7585 (Chinese dialects)
TTY users call **711**

24 hours a day, seven days a week (except closed holidays)

Visit Member Services Department at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)

Write Member Services Department at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)

Website **kp.org**

Cost Share estimates

For information about estimates, see “Getting an estimate of your Cost Share” under “Your Cost Share” in the “Benefits” section.

Plan Facilities

Plan Medical Offices and Plan Hospitals are listed in the Provider Directory for your Home Region. The directory describes the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services. This directory is available on our website at **kp.org/facilities**. To obtain a printed copy, call our Member Service Contact Center. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

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 (for Emergency Department locations, refer to our Provider Directory or call our Member Service Contact Center)

- Same-day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call our Member Service Contact Center)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (for locations, refer to our Provider Directory or call our Member Service Contact Center)

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 Contact Center, to ensure that you can obtain the health care services that you need.

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

Emergency 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.

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 in a hospital (including the Emergency Department) after your treating physician determines that this condition is Stabilized. Post-Stabilization Care also includes durable medical equipment covered under this *EOC*, if it is Medically Necessary after discharge from a hospital, and related to the same Emergency Medical Condition. For more information about durable medical equipment covered under this *EOC*, see “Durable Medical Equipment (“DME”) for Home Use” in the “Benefits” section. We cover Post-Stabilization Care from a Non-Plan Provider 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 prior authorization, the Non-Plan Provider must call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non-Plan Provider. If we determine that you require Post-Stabilization Care and that this care is part of your covered benefits, 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 Post-Stabilization Care or related transportation provided by Non-Plan Providers that has not been authorized. If you receive care from a Non-Plan Provider that we have not authorized, you may have to pay the full cost of that care. If you are admitted to a Non-Plan Hospital, please notify us as soon as possible by calling **1-800-225-8883** or the notification phone number on your ID card.

Your Cost Share

Your Cost Share for covered Emergency Services and Post-Stabilization Care is described in the “Cost Share Summary” section of this *EOC*. Your Cost Share is the same whether you receive the Services from a Plan Provider or a Non-Plan Provider. For example:

- If you receive Emergency Services in the Emergency Department of a Non-Plan Hospital, you pay the Cost Share for an Emergency Department visit as described in the “Cost Share Summary” under “Emergency and Urgent Care visits”

- If we gave prior authorization for inpatient Post-Stabilization Care in a Non-Plan Hospital, you pay the Cost Share for hospital inpatient care as described in the “Cost Share Summary” under “Hospital inpatient care”
- If we gave prior authorization for durable medical equipment after discharge from a Non-Plan Hospital, you pay the Cost Share for durable medical equipment as described in the “Cost Share Summary” under “Durable Medical Equipment (“DME”) for home use”

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 phone number at a Plan Facility. For appointment and advice phone numbers, refer to our Provider Directory or call our Member Service Contact Center.

Out-of-Area Urgent Care

If you need Urgent Care 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
- A reasonable person would have 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 if the Services would have been covered under this *EOC* if you had received them from Plan Providers.

To obtain follow-up care from a Plan Provider, call the appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call our Member Service Contact Center. We do not cover follow-up care from Non-Plan Providers after you no longer need Urgent Care, except for durable medical equipment covered under this *EOC*. For more information about durable medical equipment covered under this *EOC*, see “Durable Medical Equipment (“DME”) for Home Use” in the “Benefits” section. If you require durable medical equipment related to your

Urgent Care after receiving Out-of-Area Urgent Care, your provider must obtain prior authorization as described under “Getting a Referral” in the “How to Obtain Services” section.

Your Cost Share

Your Cost Share for covered Urgent Care is the Cost Share required for Services provided by Plan Providers as described in the “Cost Share Summary” section of this *EOC*. For example:

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non-Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described in the “Cost Share Summary” under “Emergency and Urgent Care visits”
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described in the “Cost Share Summary” under “Outpatient imaging, laboratory, and other diagnostic and treatment Services,” in addition to the Cost Share for the Urgent Care evaluation
- If we gave prior authorization for durable medical equipment provided as part of Out-of-Area Urgent Care, you pay the Cost Share for durable medical equipment as described in the “Cost Share Summary” under “Durable Medical Equipment (“DME”) for home use”

Note: If you receive Urgent Care in an Emergency Department, you pay the Cost Share for an Emergency Department visit as described in the “Cost Share Summary” under “Emergency and Urgent Care visits.”

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” section, you are not responsible for any amounts beyond your Cost Share for covered Emergency Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. 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.

For information on how to file a claim, please see the “Post-Service Claims and Appeals” section.

Benefits

This section describes the Services that are covered under this *EOC*.

Services are covered under this *EOC* as specifically described in this *EOC*. Services that are not specifically described in this *EOC* are not covered, except as required by state or federal law. Services are subject to exclusions and limitations described in the “Exclusions, Limitations, Coordination of Benefits, and Reductions” section. Except as otherwise described in this *EOC*, all of the following conditions must be 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:
 - ◆ Preventive Services
 - ◆ health care items and services for diagnosis, assessment, or treatment
 - ◆ health education covered under “Health Education” in this “Benefits” section
 - ◆ other health care items and services
 - ◆ other services to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness
- The Services are provided, prescribed, authorized, or directed by a Plan Physician, except for:
 - ◆ drugs prescribed by dentists, as described under “Outpatient Prescription Drugs, Supplies, and Supplements” below
 - ◆ emergency ambulance Services, as described under “Ambulance Services” below
 - ◆ Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the “Emergency Services and Urgent Care” section
 - ◆ Visiting Member Services, as described under “Receiving Care Outside of Your Home Region” in the “How to Obtain Services” section
- You receive the Services from Plan Providers inside our Service Area, except for:
 - ◆ authorized referrals, as described under “Getting a Referral” in the “How to Obtain Services” section
 - ◆ emergency ambulance Services, as described under “Ambulance Services” below
 - ◆ 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” below
- ◆ Visiting Member Services, as described under “Receiving Care Outside of Your Home Region” in the “How to Obtain Services” section
- The Medical Group has given prior authorization for the Services, if required, as described under “Medical Group authorization procedure for certain referrals” in the “How to Obtain Services” section

Please also 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
- Our Provider Directory for the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services

Your Cost Share

Your Cost Share is the amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance.

If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Please refer to the “Cost Share Summary” section of this *EOC* for the amount you will pay for Services.

General rules, examples, and exceptions

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

- If you are receiving covered inpatient hospital or Skilled Nursing Facility Services on the effective date of this *EOC*, you pay the Cost Share 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 Share in effect on the date you receive the Services

- For items ordered in advance, you pay the Cost Share 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 Share 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

Cost Share for Services received by newborn children of a Member

During the 31 days of automatic coverage for newborn children described under “Newborn coverage” under “Who Is Eligible” in the “Premiums, Eligibility, and Enrollment” section, the parent or guardian of the newborn must pay the Cost Share indicated in the “Cost Share Summary” section of this *EOC* for any Services that the newborn receives, whether or not the newborn is enrolled. When the “Cost Share Summary” indicates the Services are subject to the Plan Deductible, the Cost Share for those Services will be Charges if the newborn has not met the Plan Deductible.

Payment toward your Cost Share (and when you may be billed)

In most cases, your provider will ask you to make a payment toward your Cost Share at the time you receive Services. If you receive more than one type of Services (such as a routine physical maintenance exam and laboratory tests), you may be required to pay separate Cost Share for each of those Services. Keep in mind that your payment toward your Cost Share may cover only a portion of your total Cost Share for the Services you receive, and you will be billed for any additional amounts that are due. The following are examples of when you may be asked to pay (or you may be billed for) Cost Share amounts in addition to the amount you pay at check-in:

- You receive non-preventive Services during a preventive visit. For example, you go in for a routine physical maintenance exam, and at check-in you pay your Cost Share for the preventive exam (your Cost Share may be “no charge”). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional non-preventive diagnostic Services
- You receive diagnostic Services during a treatment visit. For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem

with your health and performs or orders diagnostic Services (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional diagnostic Services

- You receive treatment Services during a diagnostic visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay (or you will be billed for) your Cost Share for these additional treatment Services
- You receive Services from a second provider during your visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay (or you will be billed for) your Cost Share for the consultation with the specialist

In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for your Cost Share (for example, some Laboratory Departments are not able to collect Cost Share, or your Plan Provider is not able to collect Cost Share, if any, for Telehealth Visits you receive at home).

When we send you a bill, it will list Charges for the Services you received, payments and credits applied to your account, and any amounts you still owe. Your current bill may not always reflect your most recent Charges and payments. Any Charges and payments that are not on the current bill will appear on a future bill. Sometimes, you may see a payment but not the related Charges for Services. That could be because your payment was recorded before the Charges for the Services were processed. If so, the Charges will appear on a future bill. Also, you may receive more than one bill for a single outpatient visit or inpatient stay. For example, you may receive a bill for physician services and a separate bill for hospital services. If you don't see all the Charges for Services on one bill, they will appear on a future bill. If we determine that you overpaid and are due a refund, then we will send a refund to you within four weeks after we make that determination. If you have questions about a bill, please call the phone number on the bill.

In some cases, a Non-Plan Provider may be involved in the provision of covered Services at a Plan Facility or a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the covered Services you

receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the “Post-Service Claims and Appeals” section.

Primary Care Visits, Non-Physician Specialist Visits, and Physician Specialist Visits

The Cost Share for a Primary Care Visit applies to evaluations and treatment provided by generalists in internal medicine, pediatrics, or family practice, and by specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Some physician specialists provide primary care in addition to specialty care but are not designated as Primary Care Physicians. If you receive Services from one of these specialists, the Cost Share for a Physician Specialist Visit will apply to all consultations, evaluations, and treatment provided by the specialist except for routine preventive counseling and exams listed under “Preventive Services” in this “Benefits” section. For example, if your personal Plan Physician is a specialist in internal medicine or obstetrics/gynecology who is not a Primary Care Physician, you will pay the Cost Share for a Physician Specialist Visit for all consultations, evaluations, and treatment by the specialist except routine preventive counseling and exams listed under “Preventive Services” in this “Benefits” section. The Non-Physician Specialist Visit Cost Share applies to consultations, evaluations, and treatment provided by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Noncovered Services

If you receive Services that are not covered under this *EOC*, you may have to pay the full price of those Services. Payments you make for noncovered Services do not apply to any deductible or out-of-pocket maximum.

Benefit limits

Some benefits may include a limit on the number of visits, days, or dollar amount that will be covered under your plan during a specified time period. If a benefit includes a limit, this will be indicated in the “Cost Share Summary” section of this *EOC*. The time period associated with a benefit limit may not be the same as the term of this *EOC*. We will count all Services you receive during the benefit limit period toward the benefit limit, including Services you received under a prior Health Plan *EOC* (as long as you have continuous coverage with Health Plan). Note: We will not count Services you received under a prior Health Plan *EOC* when you first enroll in individual plan coverage or a new employer

group’s plan, when you move from group to individual plan coverage (or vice versa), or when you received Services under a Kaiser Permanente Senior Advantage evidence of coverage. If you are enrolled in the Kaiser Permanente POS Plan, refer to your KPIC *Certificate of Insurance* and *Schedule of Coverage* for benefit limits that apply to your separate indemnity coverage provided by the Kaiser Permanente Insurance Company (“KPIC”).

Getting an estimate of your Cost Share

If you have questions about the Cost Share for specific Services that you expect to receive or that your provider orders during a visit or procedure, please visit our website at kp.org/memberestimates to use our cost estimate tool or call our Member Service Contact Center.

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call **1-800-390-3507** (TTY users call **711**) Monday through Friday 7 a.m. to 7 p.m. Refer to the “Cost Share Summary” section of this *EOC* to find out if you have a Plan Deductible
- For all other Cost Share estimates, please call **1-800-464-4000** (TTY users call **711**) 24 hours a day, seven days a week (except closed holidays)

Cost Share estimates are based on your benefits and the Services you expect to receive. They are a prediction of cost and not a guarantee of the final cost of Services. Your final cost may be higher or lower than the estimate since not everything about your care can be known in advance.

Drug Deductible

This *EOC* does not include a Drug Deductible.

Plan Deductible

This *EOC* does not include a Plan Deductible.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service, after you meet any applicable deductible, is described in this *EOC*.

Note: If Charges for Services are less than the Copayment described in this *EOC*, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum.

Plan Out-of-Pocket Maximum

There is a limit to the total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for covered Services that you receive in the same Accumulation Period. The Services that apply to the Plan Out-of-Pocket Maximum are described under the

“Payments that count toward the Plan Out-of-Pocket Maximum” section below. Please refer to the “Cost Share Summary” section of this *EOC* for your applicable Plan Out-of-Pocket Maximum amounts.

If you are a Member in a Family of two or more Members, you reach the Plan Out-of-Pocket Maximum either when you reach the maximum for any one Member, or when your Family reaches the Family maximum. For example, suppose you have reached the Plan Out-of-Pocket Maximum for any one Member. For Services subject to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share during the remainder of the Accumulation Period, but every other Member in your Family must continue to pay Cost Share during the remainder of the Accumulation Period until either they reach the maximum for any one Member or your Family reaches the Family maximum.

Payments that count toward the Plan Out-of-Pocket Maximum

Any payments you make toward the Plan Deductible or Drug Deductible, if applicable, apply toward the maximum.

Most Copayments and Coinsurance you pay for covered Services apply to the maximum, however some may not. To find out whether a Copayment or Coinsurance for a covered Service will apply to the maximum please refer to the “Cost Share Summary” section of this *EOC*.

If your plan includes pediatric dental Services described in a Pediatric Dental Services Amendment to this *EOC*, those Services will apply toward the maximum. If your plan has a Pediatric Dental Services Amendment, it will be attached to this *EOC*, and it will be listed in the *EOC*'s Table of Contents.

Keeping track of the Plan Out-of-Pocket Maximum

When you receive Services, we will give you a receipt that shows how much you paid. To see how close you are to reaching your Plan Out-of-Pocket Maximum, use our online Out-of-Pocket Summary tool at kp.org/outofpocket or call our Member Service Contact Center.

Administered Drugs and Products

Administered drugs and products are medications and products that require administration or observation by medical personnel, such as:

- Whole blood, red blood cells, plasma, and platelets
- Allergy antigens (including administration)
- Cancer chemotherapy drugs and adjuncts

- Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products (“biologics”) derived from tissue, cells, or blood
- Other administered drugs and products

We cover these items when prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility or during home visits.

Certain administered drugs are Preventive Services. Please refer to “Family Planning Services” for information about administered contraceptives and refer to “Preventive Services” for information on immunizations.

Ambulance Services

Emergency

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

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

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you are not responsible for any amounts beyond your Cost Share for covered emergency ambulance Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the “Post-Service Claims and Appeals” section.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance and psychiatric transport van Services 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(s)

- 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, other diagnostic and treatment Services, and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

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

For covered Services related to bariatric surgical procedures that you receive, you will pay the Cost Share you would pay if the Services were not related to a bariatric surgical procedure. For example, see “Hospital inpatient care” in the “Cost Share Summary” section of this *EOC* for the Cost Share that applies for hospital inpatient care.

For the following Services related to “Bariatric Surgery,” refer to these sections

- Outpatient prescription drugs (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)
- Outpatient administered drugs (refer to “Administered Drugs and Products”)

Behavioral Health Treatment for Pervasive Developmental Disorder or Autism

The following terms have special meaning when capitalized and used in this “Behavioral Health Treatment for Pervasive Developmental Disorder or Autism” section:

- “Qualified Autism Service Provider” means a provider who has the experience and competence to design, supervise, provide, or administer treatment for pervasive developmental disorder or autism and is either of the following:
 - ◆ a person who is certified by a national entity (such as the Behavior Analyst Certification Board) with a certification that is accredited by the National Commission for Certifying Agencies
 - ◆ a person licensed in California as a physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist
- “Qualified Autism Service Professional” means an individual who meets all of the following criteria:
 - ◆ provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider
 - ◆ is supervised by a Qualified Autism Service Provider
 - ◆ provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
 - ◆ is a behavioral health treatment provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program
 - ◆ has training and experience in providing Services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code
 - ◆ is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan

- “Qualified Autism Service Paraprofessional” means an unlicensed and uncertified individual who meets all of the following criteria:
 - ◆ is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice
 - ◆ provides treatment and implements Services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
 - ◆ meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations
 - ◆ has adequate education, training, and experience, as certified by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers
 - ◆ is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan

We cover behavioral health treatment for pervasive developmental disorder or autism (including applied behavior analysis and evidence-based behavior intervention programs) that develops or restores, to the maximum extent practicable, the functioning of a person with pervasive developmental disorder or autism and that meets all of the following criteria:

- The Services are provided inside our Service Area
- The treatment is prescribed by a Plan Physician, or is developed by a Plan Provider who is a psychologist
- The treatment is provided under a treatment plan prescribed by a Plan Provider who is a Qualified Autism Service Provider
- The treatment is administered by a Plan Provider who is one of the following:
 - ◆ a Qualified Autism Service Provider
 - ◆ a Qualified Autism Service Professional supervised by the Qualified Autism Service Provider
 - ◆ a Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the Member being treated

- The treatment plan is reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate
- The treatment plan requires the Qualified Autism Service Provider to do all of the following:
 - ◆ describe the Member’s behavioral health impairments to be treated
 - ◆ design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan’s goal and objectives, and the frequency at which the Member’s progress is evaluated and reported
 - ◆ provide intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism
 - ◆ discontinue intensive behavioral intervention Services when the treatment goals and objectives are achieved or no longer appropriate
- The treatment plan is not used for either of the following:
 - ◆ for purposes of providing (or for the reimbursement of) respite care, day care, or educational services
 - ◆ to reimburse a parent for participating in the treatment program

For the following Services related to “Behavioral Health Treatment for Pervasive Developmental Disorder or Autism,” refer to these sections

- Behavioral health treatment for pervasive developmental disorder or autism provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to “Hospital Inpatient Care” and “Skilled Nursing Facility Care”)
- Outpatient drugs, supplies, and supplements (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)
- Outpatient laboratory (refer to “Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services”)
- Outpatient physical, occupational, and speech therapy visits (refer to “Rehabilitative and Habilitative Services”)
- Services to diagnose pervasive developmental disorder or autism and Services to develop and revise the treatment plan (refer to “Mental Health Services”)

Dental and Orthodontic Services

We do not cover most dental and orthodontic Services under this *EOC*, but we do cover some dental and orthodontic Services as described in this “Dental and Orthodontic Services” section.

For covered dental and orthodontic procedures that you may receive, you will pay the Cost Share you would pay if the Services were not related to dental and orthodontic Services. For example, see “Hospital inpatient care” in the “Cost Share Summary” section of this *EOC* for the Cost Share that applies for hospital inpatient care.

Dental Services for radiation treatment

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

Dental anesthesia

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

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

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

Dental and orthodontic Services for cleft palate

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

- The Services are an integral part of a reconstructive surgery for cleft palate that we are covering under “Reconstructive Surgery” in this “Benefits” section (“cleft palate” includes cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate)
- 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)

For the following Services related to “Dental and Orthodontic Services,” refer to these sections

- Accidental injury to teeth (refer to “Injury to Teeth”)
- Office visits not described in the “Dental and Orthodontic Services” section (refer to “Office Visits”)
- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to “Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services”)
- Outpatient administered drugs (refer to “Administered Drugs and Products”), 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”)
- Telehealth Visits (refer to “Telehealth Visits”)

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. 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.

For the following Services related to “Dialysis Care,” refer to these sections

- Durable medical equipment for home use (refer to “Durable Medical Equipment (“DME”) for Home Use”)
- Hospital inpatient care (refer to “Hospital Inpatient Care”)

- Office visits not described in the “Dialysis Care” section (refer to “Office Visits”)
- Outpatient laboratory (refer to “Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services”)
- Outpatient prescription drugs (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)
- Outpatient administered drugs (refer to “Administered Drugs and Products”)
- Telehealth Visits (refer to “Telehealth Visits”)

Dialysis care exclusion(s)

- 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 (“DME”) for Home Use

DME coverage rules

DME for home use is an item that meets the following criteria:

- The item is intended for repeated use
- The item is primarily and customarily used to serve a medical purpose
- The item is generally useful only to an individual with an illness or injury
- The item is appropriate for use in the home

For a DME item to be covered, all of the following requirements must be met:

- Your *EOC* includes coverage for the requested DME item
- A Plan Physician has prescribed the DME item for your medical condition
- The item has been approved for you through the Plan’s prior authorization process, as described in “Medical Group authorization procedure for certain referrals” under “Getting a Referral” in the “How to Obtain Services” section
- The Services are provided inside our Service Area

Coverage is limited to the standard item of equipment that adequately meets your medical needs. 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.

Base DME Items

We cover Base DME Items (including repair or replacement of covered equipment) if all of the requirements described under “DME coverage rules” in this “Durable Medical Equipment (“DME”) for Home Use” section are met. “Base DME Items” means the following items:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Bone stimulator
- Canes (standard curved handle or quad) and replacement supplies
- Cervical traction (over door)
- Crutches (standard or forearm) and replacement supplies
- Dry pressure pad for a mattress
- Infusion pumps (such as insulin pumps) and supplies to operate the pump
- IV pole
- Nebulizer and supplies
- Peak flow meters
- Phototherapy blankets for treatment of jaundice in newborns

Supplemental DME items

We cover DME that is not described under “Base DME Items” or “Breastfeeding supplies,” including repair and replacement of covered equipment, if all of the requirements described under “DME coverage rules” in this “Durable Medical Equipment (“DME”) for Home Use” section are met.

Breastfeeding supplies

We cover one retail-grade breast pump per pregnancy and the necessary supplies to operate it, such as one set of bottles. We will decide whether to rent or purchase the item and we choose the vendor. We cover this pump for convenience purposes. The pump is not subject to prior authorization requirements.

If you or your baby has a medical condition that requires the use of a breast pump, we cover a hospital-grade breast pump and the necessary supplies to operate it, in accord with the coverage rules described under “DME coverage rules” in this “Durable Medical Equipment (“DME”) for Home Use” section.

Outside our Service Area

We do not cover most DME for home use outside our Service Area. However, if you live outside our Service

Area, we cover the following DME (subject to the Cost Share and all other coverage requirements that apply to DME for home use inside our Service Area) when the item is dispensed at a Plan Facility:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
- Canes (standard curved handle)
- Crutches (standard)
- Insulin pumps and supplies to operate the pump, 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

For the following Services related to “Durable Medical Equipment (“DME”) for Home Use,” refer to these sections

- 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 an Emergency Medical Condition or Urgent Care episode (refer to “Post-Stabilization Care” and “Out-of-Area Urgent Care”)
- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to “Hospice Care”)
- Insulin and any other drugs administered with an infusion pump (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)

DME for home use exclusion(s)

- Comfort, convenience, or luxury equipment or features except for retail-grade breast pumps as described under “Breastfeeding supplies” in this “Durable Medical Equipment (“DME”) for Home Use” section
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for recreational or sports activities)
- 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
- Repair or replacement of equipment due to loss, theft, or misuse

Emergency and Urgent Care Visits

We cover the following Emergency and Urgent Care visits:

- Emergency Department visits
- Urgent Care consultations, evaluations, and treatment

Family Planning Services

We cover the following family planning Services:

- Family planning counseling
- Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices (“IUDs”) and office visits related to their administration and management
- Female sterilization procedures
- Male sterilization procedures
- Termination of pregnancy

For the following Services related to “Family Planning Services,” refer to these sections

- Services to diagnose or treat infertility (refer to “Fertility Services”)
- Outpatient administered drugs that are not contraceptives (refer to “Administered Drugs and Products”)
- Outpatient laboratory and imaging services associated with family planning services (refer to “Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services”)
- Outpatient contraceptive drugs and devices (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)

Family planning Services exclusion(s)

- Reversal of voluntary sterilization

Fertility Services

“Fertility Services” means treatments and procedures to help you become pregnant.

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

Diagnosis and treatment of infertility

For purposes of this “Diagnosis and treatment of infertility” section, “infertility” means not being able to get pregnant or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or having a medical or other demonstrated condition that is recognized by a Plan Physician as a cause of infertility.

We cover the following Services for the diagnosis and treatment of infertility:

- Office visits
- Outpatient surgery and procedures
- Outpatient imaging, laboratory, and diagnostic Services
- Outpatient administered drugs that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility
- Inpatient hospital stay directly related to diagnosis and treatment of infertility

Artificial insemination

We cover the following Services for artificial insemination:

- Office visits
- Outpatient surgery and procedures
- Outpatient imaging, laboratory, and diagnostic Services
- Outpatient administered drugs that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility

- Inpatient hospital stays directly related to diagnosis and treatment of infertility

Assisted reproductive technology (“ART”) Services

ART Services such as in vitro fertilization (“IVF”), gamete intra-fallopian transfer (“GIFT”), or zygote intrafallopian transfer (“ZIFT”) are not covered under this *EOC*.

For the following Services related to “Fertility Services,” refer to these sections

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

Fertility Services exclusion(s)

- Services to reverse voluntary, surgically induced infertility
- Semen and eggs (and Services related to their procurement and storage)
- ART Services, such as ovum transplants, GIFT, IVF, and ZIFT

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 *EOC*.

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

For more information about our health education counseling, programs, and materials, please contact a Health Education Department or our Member Service Contact Center or go to our website at kp.org.

Hearing Services

We cover the following:

- Hearing exams with an audiologist to determine the need for hearing correction
- Physician Specialist Visits to diagnose and treat hearing problems

Hearing aids

Hearing aids and related Services are not covered under this *EOC*. For internally implanted devices, see “Prosthetic and Orthotic Devices” in this “Benefits” section.

For the following Services related to “Hearing Services,” refer to these sections

- Routine hearing screenings when performed as part of a routine physical maintenance exam (refer to “Preventive Services”)
- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection or outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this “Benefits” section)
- Cochlear implants and osseointegrated hearing devices (refer to “Prosthetic and Orthotic Devices”)

Hearing Services exclusion(s)

- 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 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 Accumulation Period (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.

For the following Services related to “Home Health Care,” refer to these sections

- Behavioral health treatment for pervasive developmental disorder or autism (refer to “Behavioral Health Treatment for Pervasive Developmental Disorder or Autism”)
- Dialysis care (refer to “Dialysis Care”)
- Durable medical equipment (refer to “Durable Medical Equipment (“DME”) for Home Use”)
- Ostomy and urological supplies (refer to “Ostomy and Urological Supplies”)
- Outpatient drugs, supplies, and supplements (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)
- Outpatient physical, occupational, and speech therapy visits (refer to “Rehabilitative and Habilitative Services”)
- Prosthetic and orthotic devices (refer to “Prosthetic and Orthotic Devices”)

Home health care exclusion(s)

- 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 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
- A Plan Physician determines that 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, if necessary for your hospice care:

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, and 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 a Plan Pharmacy. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call our Member Service Contact 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

We also cover the following hospice Services only during periods of crisis when they are Medically Necessary 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

Hospital Inpatient Care

We cover the following inpatient Services 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" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and other diagnostic and treatment Services, including MRI, CT, and PET scans
- Whole blood, red blood cells, plasma, platelets, 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 “Office Visits” in this “Benefits” section)

- Behavioral health treatment for pervasive developmental disorder or autism
- Respiratory therapy
- Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation program)
- Medical social services and discharge planning

For Services related to “Hospital Inpatient Care,” refer to these sections

- Bariatric Surgery
- Dental and Orthodontic Services
- Dialysis Care
- Fertility Services
- Hospice Care
- Mental Health Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services in Connection with a Clinical Trial
- Skilled Nursing Facility Care
- Substance Use Disorder Treatment
- Transplant Services

Injury to Teeth

Services for accidental injury to teeth are not covered under this *EOC*.

Mental Health Services

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

“Mental Disorders” include the following conditions:

- Severe Mental Illness of a person of any age
- Serious Emotional Disturbance of a Child Under Age 18

In addition to the Services described in this Mental Health Services section, we also cover other Services that are Medically Necessary to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness, if the Medical Group authorizes a written referral (as described in “Medical Group authorization procedure for certain referrals” under “Getting a Referral” in the “How to Obtain Services” section).

Outpatient mental health Services

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

- Individual and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

Intensive psychiatric treatment programs

We cover the following intensive psychiatric treatment programs at a Plan Facility:

- Partial hospitalization
- Multidisciplinary treatment in an intensive outpatient program
- Psychiatric observation for an acute psychiatric crisis

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized mental health treatment, the Services are generally and customarily provided by a mental health residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group mental health evaluation and treatment
- Medical services
- Medication monitoring
- Room and board
- Social services

- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, please refer to “Outpatient Prescription Drugs, Supplies, and Supplements” in this “Benefits” section)
- Discharge planning

Inpatient psychiatric hospitalization

We cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license.

For the following Services related to “Mental Health Services,” refer to these sections

- Outpatient drugs, supplies, and supplements (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)
- Outpatient laboratory (refer to “Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services”)
- Telehealth Visits (refer to “Telehealth Visits”)

Office Visits

We cover the following:

- Primary Care Visits and Non-Physician Specialist Visits
- Physician Specialist Visits
- Group appointments
- 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)
- 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

Ostomy and Urological Supplies

We cover ostomy and urological supplies if the following requirements are met:

- A Plan Physician has prescribed ostomy and urological supplies for your medical condition

- The item has been approved for you through the Plan’s prior authorization process, as described in “Medical Group authorization procedure for certain referrals” under “Getting a Referral” in the “How to Obtain Services” section
- The Services are provided inside our Service Area

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor.

Ostomy and urological supplies exclusion(s)

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services

We cover the following Services only when part of care covered under other headings in this “Benefits” section. The Services must be prescribed by a Plan Provider.

- Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans
- Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds
- Nuclear medicine
- Routine retinal photography screenings
- Laboratory tests (including tests to monitor the effectiveness of dialysis and tests for specific genetic disorders for which genetic counseling is available)
- Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs)
- Radiation therapy
- Ultraviolet light treatments

For the following Services related to “Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services,” refer to these sections

- Outpatient imaging and laboratory Services that are Preventive Services, such as routine mammograms, bone density scans, and laboratory screening tests (refer to “Preventive Services”)
- Outpatient procedures that include imaging and diagnostic Services (refer to “Outpatient Surgery and Outpatient Procedures”)
- Services related to diagnosis and treatment of infertility, artificial insemination, or assisted

reproductive technology (“ART”) Services (refer to “Fertility Services”)

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this “Outpatient Prescription Drugs, Supplies, and Supplements” section, in accord with our drug formulary guidelines, subject to any applicable exclusions or limitations under this *EOC*. We cover items described in this section when prescribed as follows:

- Items prescribed by Plan Providers, within the scope of their licensure and practice
- Items prescribed by the following Non-Plan Providers:
 - ◆ Dentists if the drug is for dental care
 - ◆ Non-Plan Physicians if the Medical Group authorizes a written referral to the Non-Plan Physician (in accord with “Medical Group authorization procedure for certain referrals” under “Getting a Referral” in the “How to Obtain Services” section) and the drug, supply, or supplement is covered as part of that referral
 - ◆ Non-Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the “Emergency Services and Urgent Care” section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described under “Payment and Reimbursement” in the “Emergency Services and Urgent Care” section)

How to obtain covered items

You must obtain covered items at a Plan Pharmacy or through our mail-order service unless you obtain the item as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the “Emergency Services and Urgent Care” section.

For the locations of Plan Pharmacies, refer to our Provider Directory or call our Member Service Contact Center.

Refills

You may be able to order refills at a Plan Pharmacy, through our mail-order service, or through our website at kp.org/rxrefill. A Plan Pharmacy can give you more information about obtaining refills, including the options available to you for obtaining refills. For example, a few

Plan Pharmacies don’t dispense refills and not all drugs can be mailed through our mail-order service. Please check with a Plan Pharmacy if you have a question about whether your prescription can be mailed or obtained at a Plan Pharmacy. Items available through our mail-order service are subject to change at any time without notice.

Day supply limit

The prescribing physician or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians determine the amount of an item that constitutes a Medically Necessary 30- or 100-day supply (or 365-day supply if the item is a hormonal contraceptive) for you. Upon payment of the Cost Share specified in the “Outpatient prescription drugs, supplies, and supplements” section of the “Cost Share Summary,” you will receive the supply prescribed up to the day supply limit also specified in this section. The maximum you may receive at one time of a covered item, other than a hormonal contraceptive, is either one 30-day supply in a 30-day period or one 100-day supply in a 100-day period. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit.

If your plan includes coverage for hormonal contraceptives, the maximum you may receive at one time of contraceptive drugs is a 365-day supply. Refer to the “Cost Share Summary” section of this *EOC* to find out if your plan includes coverage for hormonal contraceptives.

If your plan includes coverage for sexual dysfunction drugs, the maximum you may receive at one time of episodic drugs prescribed for the treatment of sexual dysfunction disorders is eight doses in any 30-day period or up to 27 doses in any 100-day period. Refer to the “Cost Share Summary” section of this *EOC* to find out if your plan includes coverage for sexual dysfunction drugs.

The pharmacy may reduce the day supply dispensed at the Cost Share specified in the “Outpatient prescription drugs, supplies, and supplements” section of the “Cost Share Summary” to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan Pharmacy can tell you if a drug you take is one of these drugs).

About the drug formulary

The drug formulary includes a list of drugs that our Pharmacy and Therapeutics Committee has approved for our Members. Our Pharmacy and Therapeutics

Committee, which is primarily composed of Plan Physicians and pharmacists, selects drugs for the drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature. The drug formulary is updated monthly based on new information or new drugs that become available. To find out which drugs are on the formulary for your plan, please visit our website at kp.org/formulary. If you would like to request a copy of the drug formulary for your plan, please call our Member Service Contact Center. Note: The presence of a drug on the drug formulary does not necessarily mean that it will be prescribed for a particular medical condition.

Formulary exception process

Drug formulary guidelines allow you to obtain a non-formulary prescription drug (those not listed on our drug formulary for your condition) if it would otherwise be covered by your plan, as described above, and it is Medically Necessary. If you disagree with a Health Plan determination that a non-formulary prescription drug is not covered, you may file a grievance as described in the “Dispute Resolution” section.

Continuity drugs

If this *EOC* is amended to exclude a drug that we have been covering and providing to you under this *EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the Federal Food and Drug Administration.

About drug tiers

Drugs on the drug formulary are categorized into one of three tiers, as described in the table below. Your Cost Share for covered items may vary based on the tier. Please refer to “Outpatient prescription drugs, supplies, and supplements” in the “Cost Share Summary” section of this *EOC* for Cost Share for items covered under this section.

Drug Tier	Description
Generic drugs (Tier 1)	Generic drugs, supplies and supplements, and some low-cost brand-name drugs, supplies, and supplements
Brand drugs (Tier 2)*	Most brand-name drugs, supplies, and supplements
Specialty drugs (Tier 4)	Specialty drugs (see “About specialty drugs”)

*Note: This plan does not have a tier for non-formulary drugs (“Tier 3”). You will pay the same Cost Share for non-formulary drugs as you would for formulary drugs, when approved through the formulary exception process described above (the generic drugs, brand drugs, or specialty drugs Cost Share will apply, as applicable).

About specialty drugs

Specialty drugs (Tier 4) are high-cost drugs that are on our specialty drug list. To obtain a list of specialty drugs that are on our formulary, or to find out if a non-formulary drug is on the specialty drugs tier, please call our Member Service Contact Center. If your Plan Physician prescribes more than a 30-day supply for an outpatient drug, you may be able to obtain more than a 30-day supply at one time, up to the day supply limit for that drug. However, most specialty drugs are limited to a 30-day supply in any 30-day period. Your Plan Pharmacy can tell you if a drug you take is one of these drugs.

General rules about coverage and your Cost Share

We cover the following outpatient drugs, supplies, and supplements as described in this “Outpatient Prescription Drugs, Supplies, and Supplements” section:

- Drugs for which a prescription is required by law. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs

Note:

- If Charges for the drug, supply, or supplement are less than the Copayment, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum
- Items can change tier at any time, in accord with formulary guidelines, which may impact your Cost Share (for example, if a brand-name drug is added to the specialty drug list, you will pay the Cost Share that applies to drugs on the specialty drugs tier (Tier 4), not the Cost Share for drugs on the brand drugs tier (Tier 2))

Schedule II drugs

You or the prescribing provider can request that the pharmacy dispense less than the prescribed amount of a covered oral, solid dosage form of a Schedule II drug (your Plan Pharmacy can tell you if a drug you take is one of these drugs). Your Cost Share will be prorated

based on the amount of the drug that is dispensed. If the pharmacy does not prorate your Cost Share, we will send you a refund for the difference.

Mail-order service

Prescription refills can be mailed within 7 to 10 days at no extra cost for standard U.S. postage. The appropriate Cost Share (according to your drug coverage) will apply and must be charged to a valid credit card.

You may request mail-order service in the following ways:

- To order online, visit kp.org/rxrefill (you can register for a secure account at kp.org/registernow) or use the KP app from your smartphone or other mobile device
- Call the pharmacy phone number highlighted on your prescription label and select the mail delivery option
- On your next visit to a Kaiser Permanente pharmacy, ask our staff how you can have your prescriptions mailed to you

Note: Not all drugs can be mailed; restrictions and limitations apply.

Base drugs, supplies, and supplements

Cost Share for the following items may be different than other drugs, supplies, and supplements. Refer to “Base drugs, supplies, and supplements” in the “Cost Share Summary” section of this *EOC*:

- Certain drugs for the treatment of life-threatening ventricular arrhythmia
- Drugs for the treatment of tuberculosis
- Elemental dietary enteral formula when used as a primary therapy for regional enteritis
- Hematopoietic agents for dialysis
- Hematopoietic agents for the treatment of anemia in chronic renal insufficiency
- Human growth hormone for long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion
- Immunosuppressants and ganciclovir and ganciclovir prodrugs for the treatment of cytomegalovirus when prescribed in connection with a transplant
- Phosphate binders for dialysis patients for the treatment of hyperphosphatemia in end stage renal disease

For the following Services related to “Outpatient Prescription Drugs, Supplies, and Supplements,” refer to these sections

- Administered contraceptives (refer to “Family Planning Services”)
- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to “Durable Medical Equipment (“DME”) for Home Use”)
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to “Hospital Inpatient Care” and “Skilled Nursing Facility Care”)
- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (refer to “Hospice Care”)
- Durable medical equipment used to administer drugs (refer to “Durable Medical Equipment (“DME”) for Home Use”)
- Outpatient administered drugs that are not contraceptives (refer to “Administered Drugs and Products”)

Outpatient prescription drugs, supplies, and supplements exclusion(s)

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy’s standard packaging
- Compounded products unless the drug is listed on our drug formulary or one of the ingredients requires a prescription by law
- Drugs prescribed to shorten the duration of the common cold
- Prescription drugs for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug). This exclusion does not apply to:
 - ◆ insulin
 - ◆ over-the-counter drugs covered under “Preventive Services” in this “Benefits” section (this includes tobacco cessation drugs and contraceptive drugs)
 - ◆ an entire class of prescription drugs when one drug within that class becomes available over-the-counter
- All drugs, supplies, and supplements related to assisted reproductive technology (“ART”) Services

Outpatient Surgery and Outpatient Procedures

We cover the following outpatient care Services:

- Outpatient surgery
- Outpatient procedures (including imaging and diagnostic Services) when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or in any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort

For the following Services related to “Outpatient Surgery and Outpatient Procedures,” refer to these sections

- Outpatient procedures (including imaging and diagnostic Services) that do not require a licensed staff member to monitor your vital signs (refer to the section that would otherwise apply for the procedure; for example, for radiology procedures that do not require a licensed staff member to monitor your vital signs, refer to “Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services”)

Preventive Services

We cover a variety of Preventive Services, as listed on our website at kp.org/prevention, including the following:

- Services recommended by the United States Preventive Services Task Force with rating of “A” or “B.” The complete list of these services can be found at uspreventiveservicestaskforce.org
- Immunizations listed on the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians
- Preventive services for women recommended by the Health Resources and Services Administration and incorporated into the Affordable Care Act. The complete list of these services can be found at www.hrsa.gov/womens-guidelines

The list of Preventive Services recommended by the above organizations is subject to change. These Preventive Services are subject to all coverage requirements described in this “Benefits” section and all provisions in the “Exclusions, Limitations, Coordination of Benefits, and Reductions” section.

If you are enrolled in a grandfathered plan, certain preventive items listed on our website, such as over-the-counter drugs, may not be covered. Please refer to the “Certain preventive items” table in the “Cost Share Summary” section of this *EOC* for coverage information. If you have questions about Preventive Services, please call our Member Service Contact Center.

Note: If you receive any other covered Services that are not Preventive Services during or subsequent to a visit that includes Preventive Services on the list, you will pay the applicable Cost Share for those other Services. For example, if laboratory tests or imaging Services ordered during a preventive office visit are not Preventive Services, you will pay the applicable Cost Share for those Services.

For the following Services related to “Preventive Services,” refer to these sections

- Breast pumps and breastfeeding supplies (refer to “Breastfeeding supplies” under “Durable Medical Equipment (“DME”) for Home Use”)
- Health education programs (refer to “Health Education”)
- Outpatient drugs, supplies, and supplements that are Preventive Services (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)
- Women’s family planning counseling, consultations, and sterilization Services (refer to “Family Planning Services”)

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices coverage rules

We cover the prosthetic and orthotic devices specified in this “Prosthetic and Orthotic Devices” section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select
- The item has been approved for you through the Plan’s prior authorization process, as described in “Medical Group authorization procedure for certain referrals” under “Getting a Referral” in the “How to Obtain Services” section
- The Services are provided inside our Service Area

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

Base prosthetic and orthotic devices

If all of the requirements described under “Prosthetic and orthotic coverage rules” in this “Prosthetics and Orthotic Devices” section are met, we cover the items described in this “Base prosthetic and orthotic devices” section.

Internally implanted devices

We cover prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that we are covering under another section of this “Benefits” section.

External devices

We cover the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- After Medically Necessary removal of all or part of a breast:
 - ◆ prostheses, including custom-made prostheses when Medically Necessary
 - ◆ up to three brassieres required to hold a prosthesis in any 12-month period
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Enteral pump and supplies
- Tracheostomy tube and supplies
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

Supplemental prosthetic and orthotic devices

If all of the requirements described under “Prosthetic and orthotic coverage rules” in this “Prosthetics and Orthotic Devices” section are met, we cover the following items:

- Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
- Rigid and semi-rigid orthotic devices required to support or correct a defective body part

For the following Services related to “Prosthetic and Orthotic Devices,” refer to these sections

- Eyeglasses and contact lenses, including contact lenses to treat aniridia or aphakia (refer to “Vision Services for Adult Members” and “Vision Services for Pediatric Members”)
- Hearing aids other than internally implanted devices described in this section (refer to “Hearing Services”)
- Injectable implants (refer to “Administered Drugs and Products”)

Prosthetic and orthotic devices exclusion(s)

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described above in this “Prosthetic and Orthotic Devices” section
- Comfort, convenience, or luxury equipment or features
- Repair or replacement of device due to loss, theft, or misuse
- Shoes, shoe inserts, arch supports, or any other footwear, even if custom-made, except footwear described above in this “Prosthetic and Orthotic Devices” section for diabetes-related complications
- Prosthetic and orthotic devices not intended for maintaining normal activities of daily living (including devices intended to provide additional support for recreational or sports activities)

Reconstructive Surgery

We cover the following reconstructive surgery Services:

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

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

For covered Services related to reconstructive surgery that you receive, you will pay the Cost Share you would pay if the Services were not related to reconstructive surgery. For example, see “Hospital inpatient care” in the “Cost Share Summary” section of this *EOC* for the Cost Share that applies for hospital inpatient care, and see “Outpatient surgery and outpatient procedures” in the “Cost Share Summary” for the Cost Share that applies for outpatient surgery.

For the following Services related to “Reconstructive Surgery,” refer to these sections

- Dental and orthodontic Services that are an integral part of reconstructive surgery for cleft palate (refer to “Dental and Orthodontic Services”)
- Office visits not described in the “Reconstructive Surgery” section (refer to “Office Visits”)
- Outpatient imaging and laboratory (refer to “Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services”)
- Outpatient prescription drugs (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)
- Outpatient administered drugs (refer to “Administered Drugs and Products”)
- Prosthetics and orthotics (refer to “Prosthetic and Orthotic Devices”)
- Telehealth Visits (refer to “Telehealth Visits”)

Reconstructive surgery exclusion(s)

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance

Rehabilitative and Habilitative Services

We cover the Services described in this “Rehabilitative and Habilitative Services” section if all of the following requirements are met:

- The Services are to address a health condition
- The Services are to help you keep, learn, or improve skills and functioning for daily living
- You receive the Services at a Plan Facility unless a Plan Physician determines that it is Medically

Necessary for you to receive the Services in another location

We cover the following Services:

- Individual outpatient physical, occupational, and speech therapy
- Group outpatient physical, occupational, and speech therapy
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program

For the following Services related to “Rehabilitative and Habilitative Services,” refer to these sections

- Behavioral health treatment for pervasive developmental disorder or autism (refer to “Behavioral Health Treatment for Pervasive Developmental Disorder or Autism”)
- Home health care (refer to “Home Health Care”)
- Durable medical equipment (refer to “Durable Medical Equipment (“DME”) for Home Use”)
- Ostomy and urological supplies (refer to “Ostomy and Urological Supplies”)
- Prosthetic and orthotic devices (refer to “Prosthetic and Orthotic Devices”)
- Physical, occupational, and speech therapy provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to “Hospital Inpatient Care” and “Skilled Nursing Facility Care”)

Rehabilitative and habilitative Services exclusion(s)

- Items and services that are not health care items and services (for example, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including vocational training)

Services in Connection with a Clinical Trial

We cover Services you receive in connection with a clinical trial if all of the following requirements are met:

- We would have covered the Services if they were not related to a clinical trial
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is

probable unless the course of the condition is interrupted), as determined in one of the following ways:

- ◆ a Plan Provider makes this determination
- ◆ you provide us with medical and scientific information establishing this determination
- If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live
- The clinical trial is an Approved Clinical Trial

“Approved Clinical Trial” means a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition, and that meets one of the following requirements:

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having an investigational new drug application
- The study or investigation is approved or funded by at least one of the following:
 - ◆ the National Institutes of Health
 - ◆ the Centers for Disease Control and Prevention
 - ◆ the Agency for Health Care Research and Quality
 - ◆ the Centers for Medicare & Medicaid Services
 - ◆ a cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
 - ◆ a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
 - ◆ the Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved through a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review

For covered Services related to a clinical trial, you will pay the Cost Share you would pay if the Services were

not related to a clinical trial. For example, see “Hospital inpatient care” in the “Cost Share Summary” section of this *EOC* for the Cost Share that applies for hospital inpatient care.

Services in connection with a clinical trial exclusion(s)

- The investigational Service
- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management

Skilled Nursing Facility Care

Inside our Service Area, we cover skilled inpatient Services in a Plan Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our prior authorization procedure if Skilled Nursing Facilities ordinarily furnish the equipment (refer to “Medical Group authorization procedure for certain referrals” under “Getting a Referral” in the “How to Obtain Services” section)
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Whole blood, red blood cells, plasma, platelets, and their administration
- Medical supplies
- Behavioral health treatment for pervasive developmental disorder or autism
- Physical, occupational, and speech therapy
- Respiratory therapy

For the following Services related to “Skilled Nursing Facility Care,” refer to these sections

- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to “Outpatient Imaging,

Laboratory, and Other Diagnostic and Treatment Services”)

- Outpatient physical, occupational, and speech therapy (refer to “Rehabilitative and Habilitative Services”)

Substance Use Disorder Treatment

We cover Services specified in this “Substance Use Disorder Treatment” section only when the Services are for the diagnosis or treatment of Substance Use Disorders. A “Substance Use Disorder” is a condition identified as a “substance use disorder” in the most recently issued edition of the *Diagnostic and Statistical Manual of Mental Disorders (“DSM”)*.

Outpatient substance use disorder treatment

We cover the following Services for treatment of substance use disorders:

- Day-treatment programs
- Individual and group substance use disorder counseling
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder treatment, the Services are generally and customarily provided by a substance use disorder residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group substance use disorder counseling
- Medical services
- Medication monitoring
- Room and board
- Social services
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, please refer to “Outpatient Prescription Drugs, Supplies, and Supplements” in this “Benefits” section)
- Discharge planning

Inpatient detoxification

We cover hospitalization 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.

For the following Services related to “Substance Use Disorder Treatment,” refer to these sections

- Outpatient laboratory (refer to “Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services”)
- Outpatient self-administered drugs (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)
- Telehealth Visits (refer to “Telehealth Visits”)

Telehealth Visits

Telehealth Visits are intended to make it more convenient for you to receive covered Services, when a Plan Provider determines it is medically appropriate for your medical condition. You may receive covered Services via Telehealth Visits, when available and if the Services would have been covered under this *EOC* if provided in person. You are not required to use Telehealth Visits.

We cover the following types of Telehealth Visits with Primary Care Physicians, Non-Physician Specialists, and Physician Specialists:

- Interactive video visits
- Scheduled telephone visits

Transplant Services

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

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

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

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

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

For covered transplant Services that you receive, you will pay the Cost Share you would pay if the Services were not related to a transplant. For example, see “Hospital inpatient care” in the “Cost Share Summary” section of this *EOC* for the Cost Share that applies for hospital inpatient care. We provide or pay for donation-related Services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor Services at **no charge**.

For the following Services related to “Transplant Services,” refer to these sections

- Outpatient imaging and laboratory (refer to “Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services”)
- Outpatient prescription drugs (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)
- Outpatient administered drugs (refer to “Administered Drugs and Products”)

Vision Services for Adult Members

We cover the following for Adult Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical Services

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

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this “Vision Services for Adult Members” section).

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist
- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

Low vision devices

Low vision devices (including fitting and dispensing) are not covered under this *EOC*.

For the following Services related to “Vision Services for Adult Members,” refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to “Preventive Services”)
- Services related to the eye or vision other than Services covered under this “Vision Services for Adult Members” section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this “Benefits” section)

Vision Services for Adult Members exclusion(s)

- Contact lenses, including fitting and dispensing, except as described under this “Vision Services for Adult Members” section
- Eyeglass lenses and frames
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Industrial frames or safety eyeglasses, when required as a condition of employment
- Low vision devices

Vision Services for Pediatric Members

We cover the following for Pediatric Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including

dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses

- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical Services

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

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this “Vision Services for Pediatric Members” section).

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist
- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

Low vision devices

Low vision devices (including fitting and dispensing) are not covered under this *EOC*.

For the following Services related to “Vision Services for Pediatric Members,” refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to “Preventive Services”)
- Services related to the eye or vision other than Services covered under this “Vision Services for Pediatric Members” section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this “Benefits” section)

Vision Services for Pediatric Members exclusion(s)

- Contact lenses, including fitting and dispensing, except as described under this “Vision Services for Pediatric Members” section
- Eyeglass lenses and frames

- Eye exams for the purpose of obtaining or maintaining contact lenses
- Industrial frames or safety eyeglasses, when required as a condition of employment
- Low vision devices

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this “Exclusions” section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *EOC* regardless of whether the services are within the scope of a provider’s license or certificate. These exclusions or limitations do not apply to Services that are Medically Necessary to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness.

Certain exams and Services

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

Chiropractic Services

Chiropractic Services and the Services of a chiropractor, unless you have coverage for supplemental chiropractic Services as described in an amendment to this *EOC*.

Cosmetic Services

Services that are intended primarily to change or maintain your appearance (including Cosmetic Surgery, which is defined as surgery that is performed to alter or reshape normal structures of the body in order to improve appearance), except that this exclusion does not apply to any of the following:

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

Custodial care

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

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

Dental and orthodontic Services

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

This exclusion does not apply to the following Services:

- Services covered under “Dental and Orthodontic Services” in the “Benefits” section
- Service described under “Injury to Teeth” in the “Benefits” section
- Pediatric dental Services described in a Pediatric Dental Services Amendment to this *EOC*, if any. If your plan has a Pediatric Dental Services Amendment, it will be attached to this *EOC*, and it will be listed in the *EOC*'s Table of Contents

Disposable supplies

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

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

Experimental or investigational Services

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

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

This exclusion does not apply to any of the following:

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

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

Hair loss or growth treatment

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

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under “Durable Medical Equipment (“DME”) for Home Use,” “Home Health Care,” and “Hospice Care” in the “Benefits” section.

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services for the purpose of increasing academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming, except that this exclusion for “teaching play” does not apply to Services that are part of a behavioral health therapy treatment plan and covered under “Behavioral Health Treatment for Pervasive

Developmental Disorder or Autism” in the “Benefits” section

- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy does not apply to therapy Services that are part of a physical therapy treatment plan and covered under “Home Health Care,” “Hospice Services,” “Hospital Inpatient Care,” “Rehabilitative and Habilitative Services,” or “Skilled Nursing Facility Care” in the “Benefits” section

Items and services to correct refractive defects of the eye

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

Massage therapy

Massage therapy, except that this exclusion does not apply to therapy Services that are part of a physical therapy treatment plan and covered under “Home Health Care,” “Hospice Services,” “Hospital Inpatient Care,” “Rehabilitative and Habilitative Services,” or “Skilled Nursing Facility Care” in the “Benefits” section.

Oral nutrition

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

This exclusion does not apply to any of the following:

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

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility, inpatient respite care covered in the “Hospice Care” section, or residential treatment program Services covered in the “Substance Use Disorder Treatment” and “Mental Health Services” sections.

Routine foot care items and services

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

Services not approved by the federal Food and Drug Administration

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

This exclusion does not apply to any of the following:

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

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

Services performed by unlicensed people

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

This exclusion does not apply to Services covered under “Behavioral Health Treatment for Pervasive Developmental Disorder or Autism” in the “Benefits” section.

Services related to a noncovered Service

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

would not apply and we would cover any Services that we would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. A “Surrogacy Arrangement” is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Please refer to “Surrogacy arrangements” under “Reductions” in this “Exclusions, Limitations, Coordination of Benefits, and Reductions” section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and lodging expenses

Travel and lodging expenses, except as described in our Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at kp.org/specialty-care/travel-reimbursements or by calling our Member Service Contact Center.

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as a major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor dispute.

Under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest hospital as described under “Emergency Services” in the “Emergency Services and Urgent Care” section, and we will provide coverage and reimbursement as described in that section.

Coordination of Benefits

The Services covered under this *EOC* are subject to coordination of benefits rules.

Coverage other than Medicare coverage

If you have medical or dental coverage under another plan that is subject to coordination of benefits, we will coordinate benefits with the other coverage under the

coordination of benefits rules of the California Department of Managed Health Care. Those rules are incorporated into this *EOC*.

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

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

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

Medicare coverage

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

Reductions

Employer responsibility

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

Government agency responsibility

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

Injuries or illnesses alleged to be caused by third parties

If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered Services, you must reimburse us to the maximum extent allowed under California Civil Code Section 3040. Note: This “Injuries or illnesses alleged to be caused by third parties” section does not affect your obligation to pay your Cost Share for these Services.

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

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

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

The Rawlings Group
Subrogation Mailbox
P.O. Box 2000
LaGrange, KY 40031
Fax: 1-502-753-7064

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

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

asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

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

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

Surrogacy arrangements

If you enter into a Surrogacy Arrangement and you or any other payee are entitled to receive payments or other compensation under the Surrogacy Arrangement, you must reimburse us for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement (“Surrogacy Health Services”) to the maximum extent allowed under California Civil Code Section 3040. A “Surrogacy Arrangement” is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Note: This “Surrogacy arrangements” section does not affect your obligation to pay your Cost Share for these Services. After you surrender a baby to the legal parents, you are not obligated to reimburse us for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

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

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and phone numbers of the other parties to the arrangement
- Names, addresses, and phone numbers of any escrow agent or trustee
- Names, addresses, and phone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and phone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

The Rawlings Group
Surrogacy Mailbox
P.O. Box 2000
LaGrange, KY 40031
Fax: 1-502-753-7064

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

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

If you have questions about your obligations under this provision, please contact our Member Service Contact Center.

U.S. Department of Veterans Affairs

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

we may recover the value of the Services from the Department of Veterans Affairs.

Workers’ compensation or employer’s liability benefits

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

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

Post-Service Claims and Appeals

This “Post-Service Claims and Appeals” section explains how to file a claim for payment or reimbursement for Services that you have already received. Please use the procedures in this section in the following situations:

- You have received Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services from a Non-Plan Provider and you want us to pay for the Services
- You have received Services from a Non-Plan Provider that we did not authorize (other than Emergency Services, Out-of-Area Urgent Care, Post-Stabilization Care, or emergency ambulance Services) and you want us to pay for the Services
- You want to appeal a denial of an initial claim for payment

Please follow the procedures under “Grievances” in the “Dispute Resolution” section in the following situations:

- You want us to cover Services that you have not yet received
- You want us to continue to cover an ongoing course of covered treatment
- You want to appeal a written denial of a request for Services that require prior authorization (as described under “Medical Group authorization procedure for certain referrals”)

Who May File

The following people may file claims:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a claim for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the claim
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the claim
- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services Department at a Plan Facility, on our website at **kp.org**, or by calling our Member Service Contact Center. Your written authorization must accompany the claim. You must pay the cost of anyone you hire to represent or help you.

Supporting Documents

You can request payment or reimbursement orally or in writing. Your request for payment or reimbursement, and any related documents that you give us, constitute your claim.

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

To file a claim in writing for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services, please use our claim form. You can obtain a claim form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call our Member Service Contact Center)

- By calling our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**)

Claims forms for all other Services

To file a claim in writing for all other Services, you may use our Complaint or Benefit Claim/Request form. You can obtain this form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By calling our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**)

Other supporting information

When you file a claim, please include any information that clarifies or supports your position. For example, if you have paid for Services, please include any bills and receipts that support your claim. To request that we pay a Non-Plan Provider for Services, include any bills from the Non-Plan Provider. If the Non-Plan Provider states that they will file the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. When appropriate, we will request medical records from Plan Providers on your behalf. If you tell us that you have consulted with a Non-Plan Provider and are unable to provide copies of relevant medical records, we will contact the provider to request a copy of your relevant medical records. We will ask you to provide us a written authorization so that we can request your records.

If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should follow the steps in the written notice sent to you about your claim.

Initial Claims

To request that we pay a provider (or reimburse you) for Services that you have already received, you must file a claim. If you have any questions about the claims process, please call our Member Service Contact Center.

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

If you have received Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or

emergency ambulance Services from a Non–Plan Provider, then as soon as possible after you received the Services, you must file your claim by mailing a completed claim form and supporting information to the following address:

Kaiser Permanente
Claims Administration - SCAL
P.O. Box 7004
Downey, CA 90242-7004

Please call our Member Service Contact Center if you need help filing your claim.

Submitting a claim for all other Services

If you have received Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services), then as soon as possible after you receive the Services, you must file your claim in one of the following ways:

- By delivering your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By mailing your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By calling our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Please call our Member Service Contact Center if you need help filing your claim.

After we receive your claim

We will send you an acknowledgment letter within five days after we receive your claim.

After we review your claim, we will respond as follows:

- If we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 30 days after we receive your claim
- If we need more information, we will ask you for the information before the end of the initial 30-day decision period. We will send our written decision no later than 15 days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in our letter, we will make our decision based on the

information we have within 15 days after the end of that timeframe

If we pay any part of your claim, we will subtract applicable Cost Share from any payment we make to you or the Non–Plan Provider. You are not responsible for any amounts beyond your Cost Share for covered Emergency Services. If we deny your claim (if we do not agree to pay for all the Services you requested other than the applicable Cost Share), our letter will explain why we denied your claim and how you can appeal.

If you later receive any bills from the Non–Plan Provider for covered Services (other than bills for your Cost Share), please call our Member Service Contact Center for assistance.

Appeals

Claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services from a Non–Plan Provider

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By mailing your appeal to the Claims Department at the following address:
Kaiser Foundation Health Plan, Inc.
Special Services Unit
P.O. Box 23280
Oakland, CA 94623
- By calling our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Claims for Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services)

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By visiting our website at **kp.org**
- By mailing your appeal to the Member Services Department at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call our Member Service Contact Center)

- By calling our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**)

When you file an appeal, please include any information that clarifies or supports your position. If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should contact our Member Service Contact Center.

Additional information regarding a claim for Services from a Non-Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services)

If we initially denied your request, you must file your appeal within 180 days after the date you received our denial letter. You may send us information including comments, documents, and medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Please send all additional information to the address or fax mentioned in your denial letter.

Also, you may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter, sent to you within five days after we receive your appeal. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will review it without regard to whether this information was filed or considered in our initial decision regarding your request for Services. You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our final decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If you do not respond before we must issue our final decision letter, that

decision will be based on the information in your appeal file.

We will send you a resolution letter within 30 days after we receive your appeal. If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

External Review

You must exhaust our internal claims and appeals procedures before you may request external review unless we have failed to comply with the claims and appeals procedures described in this “Post-Service Claims and Appeals” section. For information about external review process, see “Independent Medical Review (“IMR”)” in the “Dispute Resolution” section.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group’s benefit plan is subject to the Employee Retirement Income Security Act (“ERISA”), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-EBSA (1-866-444-3272)**
- If your Group’s benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Dispute Resolution

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

Grievances

This “Grievances” section describes our grievance procedure. A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. If you want to make a claim for payment or reimbursement for

Services that you have already received from a Non-Plan Provider, please follow the procedure in the “Post-Service Claims and Appeals” section.

Here are some examples of reasons you might file a grievance:

- You are not satisfied with the quality of care you received
- You received a written denial of Services that require prior authorization from the Medical Group and you want us to cover the Services
- You received a written denial for a second opinion or we did not respond to your request for a second opinion in an expeditious manner, as appropriate for your condition
- Your treating physician has said that Services are not Medically Necessary and you want us to cover the Services
- You were told that Services are not covered and you believe that the Services should be covered
- You want us to continue to cover an ongoing course of covered treatment
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility
- You believe you have faced discrimination from providers, staff, or Health Plan
- We terminated your membership and you disagree with that termination

Who may file

The following people may file a grievance:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a grievance for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the grievance
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the grievance
- A court-appointed conservator may file for their conservatee

- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal
- Your physician may act as your authorized representative with your verbal consent to request an urgent grievance as described under “Urgent procedure” in this “Grievances” section

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services Department at a Plan Facility, on our website at **kp.org**, or by calling our Member Service Contact Center. Your written authorization must accompany the grievance. You must pay the cost of anyone you hire to represent or help you.

How to file

You can file a grievance orally or in writing. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with the Services you received.

To file a grievance online, use the grievance form on our website at **kp.org**.

To file a grievance in writing, please use our Complaint or Benefit Claim/Request form. You can obtain the form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)

You must file your grievance within 180 days following the incident or action that is subject to your dissatisfaction. You may send us information including comments, documents, and medical records that you believe support your grievance.

Standard procedure

You must file your grievance in one of the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By mailing your grievance to a Member Services office at a Plan Facility (for addresses, refer to our

Provider Directory or call our Member Service Contact Center)

- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)
- By completing the grievance form on our website at **kp.org**

Please call our Member Service Contact Center if you need help filing a grievance.

If your grievance involves a request to obtain a non-formulary prescription drug, we will notify you of our decision within 72 hours. If we do not decide in your favor, our letter will explain why and describe your further appeal rights. For information on how to request a review by an independent review organization, see “Independent Review Organization for Non-Formulary Prescription Drug Requests” in this “Dispute Resolution” section.

For all other grievances, we will send you an acknowledgment letter within five days after we receive your grievance. We will send you a resolution letter within 30 days after we receive your grievance. If you are requesting Services, and we do not decide in your favor, our letter will explain why and describe your further appeal rights.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should contact our Member Service Contact Center.

Urgent procedure

If you want us to consider your grievance on an urgent basis, please tell us that when you file your grievance. Note: Urgent is sometimes referred to as “exigent.” If exigent circumstances exist, your grievance may be reviewed using the urgent procedure described in this section.

You must file your urgent grievance in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:
Kaiser Foundation Health Plan, Inc.
Expedited Review Unit
P.O. Box 23170
Oakland, CA 94623-0170

- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By completing the grievance form on our website at **kp.org**

We will decide whether your grievance is urgent or non-urgent unless your attending health care provider tells us your grievance is urgent. If we determine that your grievance is not urgent, we will use the procedure described under “Standard procedure” in this “Grievances” section. Generally, a grievance is urgent only if one of the following is true:

- Using the standard procedure could seriously jeopardize your life, health, or ability to regain maximum function
- Using the standard procedure would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment
- A physician with knowledge of your medical condition determines that your grievance is urgent
- You have received Emergency Services but have not been discharged from a facility and your request involves admissions, continued stay, or other health care Services
- You are undergoing a current course of treatment using a non-formulary prescription drug and your grievance involves a request to refill a non-formulary prescription drug

For most grievances that we respond to on an urgent basis, we will give you oral notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your grievance. We will send you a written confirmation of our decision within three days after we received your grievance.

If your grievance involves a request to obtain a non-formulary prescription drug and we respond to your request on an urgent basis, we will notify you of our decision within 24 hours of your request. For information on how to request a review by an independent review organization, see “Independent Review Organization for Non-Formulary Prescription Drug Requests” in this “Dispute Resolution” section.

If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care at any time at **1-888-466-2219** (TDD **1-877-688-9891**) without first filing a grievance with us.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should contact our Member Service Contact Center.

Additional information regarding pre-service requests for Medically Necessary Services

You may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your grievance file and we will consider it in our decision regarding your pre-service request for Medically Necessary Services.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your grievance is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your grievance file.

Additional information regarding appeals of written denials for Services that require prior authorization

You must file your appeal within 180 days after the date you received our denial letter.

You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your appeal.

Also, you may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to

give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will consider it in our decision regarding your appeal.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your appeal is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

Independent Review Organization for Non-Formulary Prescription Drug Requests

If you filed a grievance to obtain a non-formulary prescription drug and we did not decide in your favor, you may submit a request for a review of your grievance by an independent review organization (“IRO”). You must submit your request for IRO review within 180 days of the receipt of our decision letter.

You must file your request for IRO review in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:
Kaiser Foundation Health Plan, Inc.
Expedited Review Unit
P.O. Box 23170
Oakland, CA 94623-0170
- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By completing the grievance form on our website at **kp.org**

For urgent IRO reviews, we will forward to you the independent reviewer’s decision within 24 hours. For non-urgent requests, we will forward the independent

reviewer's decision to you within 72 hours. If the independent reviewer does not decide in your favor, you may submit a complaint to the Department of Managed Health Care, as described under "Department of Managed Health Care Complaints" in this "Dispute Resolution" section. You may also submit a request for an Independent Medical Review as described under "Independent Medical Review" in this "Dispute Resolution" section.

Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll free at **1-800-464-4000** (TTY users call **711**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The department's Internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review ("IMR")

Except as described in this "Independent Medical Review ("IMR")" section, you must exhaust our internal grievance procedure before you may request independent medical review unless we have failed to comply with the grievance procedure described under "Grievances" in this "Dispute Resolution" section. If you qualify, you or your authorized representative may have your issue reviewed through the IMR process managed by the California Department of Managed Health Care ("DMHC"). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you decide

not to request an IMR, you may give up the right to pursue some legal actions against us.

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

- One of these situations applies to you:
 - ◆ you have a recommendation from a provider requesting Medically Necessary Services
 - ◆ you have received Emergency Services, emergency ambulance Services, or Urgent Care from a provider who determined the Services to be Medically Necessary
 - ◆ you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for urgent grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function. If we have denied your grievance, you must submit your request for an IMR within six months of the date of our written denial. However, the DMHC may accept your request after six months if they determine that circumstances prevented timely submission

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

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

Experimental or investigational denials

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

- Your treating physician provided us a written statement that you have a life-threatening or seriously

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

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

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

Office of Civil Rights Complaints

If you believe that you have been discriminated against by a Plan Provider or by us because of your race, color, national origin, disability, age, sex (including sex stereotyping and gender identity), or religion, you may file a complaint with the Office of Civil Rights in the United States Department of Health and Human Services (“OCR”).

You may file your complaint with the OCR within 180 days of when you believe the act of discrimination occurred. However, the OCR may accept your request after six months if they determine that circumstances prevented timely submission. For more information on the OCR and how to file a complaint with the OCR, go to [hhs.gov/civil-rights](https://www.hhs.gov/civil-rights).

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group’s benefit plan is subject to the Employee Retirement Income Security Act (“ERISA”), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-EBSA (1-866-444-3272)**
- If your Group’s benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Binding Arbitration

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

Scope of arbitration

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

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *EOC* or a Member Party’s relationship to Kaiser Foundation Health Plan, Inc. (“Health Plan”), including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- Governing law does not prevent the use of binding arbitration to resolve the claim

Members enrolled under this *EOC* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

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

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

“Kaiser Permanente Parties” include:

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

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

Rules of Procedure

Arbitrations shall be conducted according to the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* (“Rules of Procedure”) developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies

of the Rules of Procedure may be obtained from our Member Service Contact Center.

Initiating arbitration

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

Serving Demand for Arbitration

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

Kaiser Foundation Health Plan, Inc.
Legal Department
393 E. Walnut St.
Pasadena, CA 91188

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

Filing fee

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

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

Number of arbitrators

The number of arbitrators may affect the Claimants’ responsibility for paying the neutral arbitrator’s fees and expenses (see the Rules of Procedure).

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

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

Payment of arbitrators' fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the Rules of Procedure. In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

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

Costs

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

General provisions

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

neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

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

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

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2022, your last minute of coverage was at 11:59 p.m. on December 31, 2021). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section.

Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements described under “Who Is Eligible” in the “Premiums, Eligibility, and Enrollment” section, your Group will notify you of the date that your membership will end. Your membership termination date is the first day you are not covered. For example, if your termination date is January 1, 2022, your last minute of coverage was at 11:59 p.m. on December 31, 2021.

Termination of Agreement

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

Termination for Cause

If you intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider, we may terminate your membership by sending written notice to the Subscriber; termination will be effective 30 days from the date we send the notice. Some examples of fraud include:

- Misrepresenting eligibility information about you or a Dependent
- Presenting an invalid prescription or physician order
- Misusing a Kaiser Permanente ID card (or letting someone else use it)
- Giving us incorrect or incomplete material information. For example, you have entered into a Surrogacy Arrangement and you fail to send us the information we require under “Surrogacy arrangements” under “Reductions” in the “Exclusions, Limitations, Coordination of Benefits, and Reductions” section
- Failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits

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

Termination of a Product or all Products

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the

group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group’s *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

Payments after Termination

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

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the “Emergency Services and Urgent Care” and “Dispute Resolution” sections

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

State Review of Membership Termination

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

Continuation of Membership

If your membership under this *EOC* ends, you may be eligible to continue Health Plan membership without a break in coverage. You may be able to continue Group coverage under this *EOC* as described under “Continuation of Group Coverage.” Also, you may be able to continue membership under an individual plan as described under “Continuation of Coverage under an Individual Plan.” If at any time you become entitled to continuation of Group coverage, please examine your coverage options carefully before declining this coverage. Individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

Continuation of Group Coverage

COBRA

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

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

If you enroll in COBRA and exhaust the time limit for COBRA coverage, you may be able to continue Group coverage under state law as described under “Cal-COBRA” in this “Continuation of Group Coverage” section.

Cal-COBRA

If you are eligible for coverage under the California Continuation Benefits Replacement Act (“Cal-COBRA”), you can continue coverage as described in this “Cal-COBRA” section if you apply for coverage in compliance with Cal-COBRA law and pay applicable Premiums.

Eligibility and effective date of coverage for Cal-COBRA after COBRA

If your group is subject to COBRA and your COBRA coverage ends, you may be able to continue Group coverage effective the date your COBRA coverage ends if all of the following are true:

- Your effective date of COBRA coverage was on or after January 1, 2003
- You have exhausted the time limit for COBRA coverage and that time limit was 18 or 29 months
- You do not have Medicare

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

Cal-COBRA enrollment and Premiums

Within 10 days of your request for an enrollment application, we will send you our application, which will include Premium and billing information. You must

return your completed application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

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

After that first payment, your Premium payment for the upcoming coverage month is due on first day of that month. The Premiums will not exceed 110 percent of the applicable Premiums charged to a similarly situated individual under the Group benefit plan except that Premiums for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent instead of 110 percent. Returned checks or insufficient funds on electronic payments will be subject to a \$25 fee.

If you have selected Ancillary Coverage provided under any other program, the Premium for that Ancillary Coverage will be billed together with required Premiums for coverage under this *EOC*. Full Premiums will then also include Premium for Ancillary Coverage. This means if you do not pay the Full Premiums owed by the due date, we may terminate your membership under this *EOC* and any Ancillary Coverage, as described in the “Termination for nonpayment of Cal-COBRA Premiums” section.

Changes to Cal-COBRA coverage and Premiums

Your Cal-COBRA coverage is the same as for any similarly situated individual under your Group’s *Agreement*, and your Cal-COBRA coverage and Premiums will change at the same time that coverage or Premiums change in your Group’s *Agreement*. Your Group’s coverage and Premiums will change on the renewal date of its *Agreement* (January 1), and may also change at other times if your Group’s *Agreement* is amended. Your monthly invoice will reflect the current Premiums that are due for Cal-COBRA coverage, including any changes. For example, if your Group makes a change that affects Premiums retroactively, the amount we bill you will be adjusted to reflect the retroactive adjustment in Premiums. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended. You can also request one from our Member Service Contact Center.

Cal-COBRA open enrollment or termination of another health plan

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

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

How you may terminate your Cal-COBRA coverage

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

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

Termination for nonpayment of Cal-COBRA Premiums

If you do not pay Full Premiums by the due date, we may terminate your membership as described in this "Termination for nonpayment of Cal-COBRA Premiums" section. If you intend to terminate your membership, be sure to notify us as described under "How you may terminate your Cal-COBRA coverage" in this "Cal-COBRA" section, as you will be responsible

for any Premiums billed to you unless you let us know before the first of the coverage month that you want us to terminate your coverage.

Your Premium payment for the upcoming coverage month is due on the first day of that month. If we do not receive full Premium payment on or before the first day of the coverage month, we will send a notice of nonreceipt of payment (a "Late Notice") to the Subscriber's address of record. This Late Notice will include the following information:

- A statement that we have not received full Premium payment and that we will terminate the memberships of everyone in your Family for nonpayment if we do not receive the required Premiums within 30 days after the date of the Late Notice
- The amount of Premiums that are due
- The specific date and time when the memberships of everyone in your Family will end if we do not receive the Premiums

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

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

- A statement that we have terminated the memberships of everyone in your Family for nonpayment of Premiums
- The specific date and time when the memberships of everyone in your Family ended
- The amount of Premiums that are due
- Information explaining whether or not you can reinstate your memberships
- Your appeal rights

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

Reinstatement of your membership after termination for nonpayment of Cal-COBRA Premiums

If we terminate your membership for nonpayment of Premiums, we will permit reinstatement of your membership three times during any 12-month period if

we receive the amounts owed within 15 days of the date of the Termination Notice. We will not reinstate your membership if you do not obtain reinstatement of your terminated membership within the required 15 days, or if we terminate your membership for nonpayment of Premiums more than three times in a 12-month period.

Termination of Cal-COBRA coverage

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

- The date your Group's *Agreement* with us terminates (you may still be eligible for Cal-COBRA through another Group health plan)
- The date you get Medicare
- The date your coverage begins under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have (or that does contain such an exclusion or limitation, but it has been satisfied)
- The date that is 36 months after your original COBRA effective date (under this or any other plan)
- The date your membership is terminated for nonpayment of Premiums as described under "Termination for nonpayment of Cal-COBRA Premiums" in this "Continuation of Membership" section

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

Group responsibilities

If your Group's agreement with a health plan is terminated, your Group is required to provide written notice at least 30 days before the termination date to the persons whose Cal-COBRA coverage is terminating. This notice must inform Cal-COBRA beneficiaries that they can continue Cal-COBRA coverage by enrolling in any health benefit plan offered by your Group. It must also include information about benefits, premiums, payment instructions, and enrollment forms (including instructions on how to continue Cal-COBRA coverage

under the new health plan). Your Group is required to send this information to the person's last known address, as provided by the prior health plan. Health Plan is not obligated to provide this information to qualified beneficiaries if your Group fails to provide the notice. These persons will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA.

USERRA

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal Uniformed Services Employment and Reemployment Rights Act ("USERRA"). You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group to find out how to elect USERRA coverage and how much you must pay your Group.

Coverage for a Disabling Condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates and is not renewed, we will cover Services for your totally disabling condition until the earliest of the following events occurs:

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

Your coverage will be subject to the terms of this *EOC*, including Cost Share, but we will not cover Services for any condition other than your totally disabling condition.

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

For Dependent children, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable

to substantially engage in any of the normal activities of children in good health of like age.

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

Continuation of Coverage under an Individual Plan

If you want to remain a Health Plan member when your Group coverage ends, you might be able to enroll in one of our Kaiser Permanente for Individuals and Families plans. The premiums and coverage under our individual plan coverage are different from those under this *EOC*.

If you want your individual plan coverage to be effective when your Group coverage ends, you must submit your application within the special enrollment period for enrolling in an individual plan due to loss of other coverage. Otherwise, you will have to wait until the next annual open enrollment period.

To request an application to enroll directly with us, please go to **kp.org** or call our Member Service Contact Center. For information about plans that are available through Covered California, see "Covered California" below.

Covered California

U.S. citizens or legal residents of the U.S. can buy health care coverage from Covered California. This is California's health insurance marketplace ("the Exchange"). You may apply for help to pay for premiums and copayments but only if you buy coverage through Covered California. This financial assistance may be available if you meet certain income guidelines. To learn more about coverage that is available through Covered California, visit **CoveredCA.com** or call Covered California at **1-800-300-1506** (TTY users call **711**).

Miscellaneous Provisions

Administration of Agreement

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

Advance Directives

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

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

To learn more about advance directives, including how to obtain forms and instructions, contact the Member Services Department at a Plan Facility. For more information about advance directives, refer to our website at **kp.org** or call our Member Service Contact Center.

Amendment of Agreement

Your Group's *Agreement* with us will change periodically. If these changes affect this *EOC*, your Group is required to inform you in accord with applicable law and your Group's *Agreement*.

Applications and Statements

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

Assignment

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

Attorney and Advocate Fees and Expenses

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

Claims Review Authority

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

EOC Binding on Members

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

ERISA Notices

This “ERISA Notices” section applies only if your Group’s health benefit plan is subject to the Employee Retirement Income Security Act (“ERISA”). We provide these notices to assist ERISA-covered groups in complying with ERISA. Coverage for Services described in these notices is subject to all provisions of this *EOC*.

Newborns’ and Mother’s Health Protection Act

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

Women’s Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women’s Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy

was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Share applicable to other medical and surgical benefits provided under this plan.

Governing Law

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

Group and Members Not Our Agents

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

No Waiver

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

Notices Regarding Your Coverage

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

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

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment or from

any person or organization obligated to pay for the Services.

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information. Your protected health information is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information. You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give protected health information to others, such as government agencies or in judicial actions. In addition, protected health information is shared with your Group only with your authorization or as otherwise permitted by law.

We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. **OUR NOTICE OF PRIVACY PRACTICES, WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY PRACTICES AND YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION, IS AVAILABLE**

AND WILL BE FURNISHED TO YOU UPON REQUEST. To request a copy, please call our Member Service Contact Center. You can also find the notice at a Plan Facility or on our website at **kp.org**.

Public Policy Participation

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

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

Helpful Information

How to Obtain this EOC in Other Formats

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

Provider Directory

Please refer to the Provider Directory for your Home Region for the following information:

- A list of Plan Physicians
- The location of Plan Facilities and the types of covered Services that are available from each facility
- Hours of operation
- Appointments and advice phone numbers

This directory is available on our website at **kp.org**. To obtain a printed copy, call our Member Service Contact Center. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

Online Tools and Resources

Here are some tools and resources available on our website at **kp.org**:

- How to use our Services and make appointments
- Tools you can use to email your doctor's office, view test results, refill prescriptions, and schedule routine appointments
- Health education resources
- Preventive care guidelines
- Member rights and responsibilities

You can also access tools and resources using the KP app on your smartphone or other mobile device.

How to Reach Us

Appointments

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

Call The appointment phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call our Member Service Contact Center)

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

Not sure what kind of care you need?

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

Call The appointment or advice phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call our Member Service Contact Center)

Member Services

If you have questions or concerns about your coverage, how to obtain Services, or the facilities where you can receive care, you can reach us in the following ways:

Call **1-800-464-4000** (English and more than 150 languages using interpreter services)
1-800-788-0616 (Spanish)
1-800-757-7585 (Chinese dialects)
TTY users call **711**

24 hours a day, seven days a week (except closed holidays)

Visit Member Services Department at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)

Write Member Services Department at a Plan Facility for addresses, refer to our Provider Directory or call our Member Service Contact Center)

Website **kp.org**

Estimates, bills, and statements

For the following concerns, please call us at the number below:

- If you have questions about a bill
- To find out how much you have paid toward your Plan Deductible (if applicable) or Plan Out-of-Pocket Maximum
- To get an estimate of Charges for Services that are subject to the Plan Deductible (if applicable)

Call **1-800-464-4000** (TTY users call **711**)
24 hours a day, seven days a week (except closed holidays)

Website **kp.org/memberestimates**

Away from home travel line

If you have questions about your coverage when you are away from home:

Call **1-951-268-3900**
24 hours a day, seven days a week (except closed holidays)

Website **kp.org/travel**

Authorization for Post-Stabilization Care

To request prior authorization for Post-Stabilization Care as described under "Emergency Services" in the "Emergency Services and Urgent Care" section:

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

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

If you need a claim form to request payment or reimbursement for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits" section, or if you need help

completing the form, you can reach us by calling or by visiting our website.

Call 1-800-464-4000 (TTY users call 711)

24 hours a day, seven days a week (except closed holidays)

Website kp.org

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

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

Write Kaiser Permanente
Claims Administration - SCAL
P.O. Box 7004
Oakland, CA 90242-7004

Text telephone access (“TTY”)

If you use a text telephone device (“TTY,” also known as “TDD”) to communicate by phone, you can use the California Relay Service by calling **711**.

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call our Member Service Contact Center.

Payment Responsibility

This “Payment Responsibility” section briefly explains who is responsible for payments related to the health care coverage described in this *EOC*. Payment responsibility is more fully described in other sections of the *EOC* as described below:

- Your Group is responsible for paying Premiums, except that you are responsible for paying Premiums if you have COBRA or Cal-COBRA (refer to “Premiums” in the “Premiums, Eligibility, and Enrollment” section and “COBRA” and “Cal-COBRA” under “Continuation of Group Coverage” in the “Continuation of Membership” section)
- Your Group may require you to contribute to Premiums (your Group will tell you the amount and how to pay)

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



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

A nonprofit corporation and a Medicare Advantage Organization

**EOC #2 - Kaiser Permanente Senior Advantage
(HMO) with Part D
Evidence of Coverage for
UNIVERSITY OF SAN FRANCISCO**

Group ID: 232239 Contract: 1 Version: 10 EOC Number: 2

January 1, 2021, through December 31, 2021

Member Service Contact Center
Seven days a week, 8 a.m.–8 p.m.
1-800-443-0815 (TTY users call **711**)
kp.org

This document is available for free in Spanish. Please contact our Member Service Contact Center number at **1-800-443-0815** for additional information. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., seven days a week.

*Esta documento está disponible de forma gratuita en español. Si desea información adicional, por favor llame al número de nuestra Central de Llamadas de Servicio a los Miembros al **1-800-443-0815** (los usuarios de la línea TTY deben llamar al **711**). El horario es de 8 a.m. a 8 p.m., los 7 días de la semana.*

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Benefit Highlights

Accumulation Period

The Accumulation Period for this plan is 1/1/21 through 12/31/21 (calendar year).

Plan Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount:

For any one Member \$1,700 per calendar year

Plan Deductible

None

Professional Services (Plan Provider office visits)

You Pay

Most Primary Care Visits and most Non-Physician Specialist Visits \$20 per visit
 Most Physician Specialist Visits..... \$20 per visit
 Annual Wellness visit and the “Welcome to Medicare” preventive visit No charge
 Routine physical exams No charge
 Routine eye exams with a Plan Optometrist..... \$20 per visit
 Urgent care consultations, evaluations, and treatment \$20 per visit
 Physical, occupational, and speech therapy..... \$20 per visit

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures \$175 per procedure
 Allergy injections (including allergy serum)..... \$3 per visit
 Most immunizations (including the vaccine) No charge
 Most X-rays and laboratory tests..... No charge
 Manual manipulation of the spine \$20 per visit

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.. \$500 per admission

Emergency Health Coverage

You Pay

Emergency Department visits..... \$50 per visit

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (see “Hospitalization Services” for inpatient Cost Share).

Ambulance and Transportation Services

You Pay

Ambulance Services \$125 per trip

Prescription Drug Coverage

You Pay

Covered outpatient items in accord with our drug formulary guidelines:

Most generic items \$10 for up to a 100-day supply
 Most brand-name items \$35 for up to a 100-day supply

Durable Medical Equipment (DME)

You Pay

Covered durable medical equipment for home use as described in this

EOC..... 20 percent Coinsurance

Mental Health Services

You Pay

Inpatient psychiatric hospitalization \$500 per admission
 Individual outpatient mental health evaluation and treatment..... \$20 per visit
 Group outpatient mental health treatment \$10 per visit

Substance Use Disorder Treatment

You Pay

Inpatient detoxification..... \$500 per admission
 Individual outpatient substance use disorder evaluation and treatment \$20 per visit
 Group outpatient substance use disorder treatment..... \$5 per visit

Home Health Services	You Pay
Home health care (part-time, intermittent).....	No charge
Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of \$150 Allowance
Skilled Nursing Facility care (up to 100 days per benefit period).....	No charge (up to 20 days) \$75 per day (days 21–100)
External prosthetic and orthotic devices as described in this <i>EOC</i>	20 percent Coinsurance
Ostomy, urological, and wound care supplies	20 percent Coinsurance
Meals delivered to your home following discharge from a hospital due to congestive heart failure.....	No charge up to two meals per day in a consecutive four-week period, once per calendar year

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

Introduction

Kaiser Foundation Health Plan, Inc. (Health Plan) has a contract with the Centers for Medicare & Medicaid Services as a Medicare Advantage Organization.

This contract provides Medicare Services (including Medicare Part D prescription drug coverage) through “Kaiser Permanente Senior Advantage (HMO) with Part D” (Senior Advantage), except for hospice care for Members with Medicare Part A, which is covered under Original Medicare. Enrollment in this Senior Advantage plan means that you are automatically enrolled in Medicare Part D. Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

This *Evidence of Coverage* (“EOC”) describes our Senior Advantage health care coverage provided under the *Group Agreement (Agreement)* between Health Plan (Kaiser Foundation Health Plan, Inc.) and your Group (the entity with which Health Plan has entered into the *Agreement*). The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

For benefits provided under any other program, refer to that other plan’s evidence of coverage. For benefits provided under any other program offered by your Group (for example, workers compensation benefits), refer to your Group’s materials.

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

It is important to familiarize yourself with your coverage by reading this *EOC* completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

About Kaiser Permanente

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY GET HEALTH CARE.

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

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

- Authorized referrals as described under “Getting a Referral” in the “How to Obtain Services” section
- Certain care when you visit the service area of another Region as described under “Receiving Care Outside of Your Home Region” in the “How to Obtain Services” section
- Emergency ambulance Services as described under “Ambulance Services” in the “Benefits and Your Cost Share” section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the “Emergency Services and Urgent Care” section
- Out-of-area dialysis care as described under “Dialysis Care” in the “Benefits and Your Cost Share” section
- Prescription drugs from Non-Plan Pharmacies as described under “Outpatient Prescription Drugs, Supplies, and Supplements” in the “Benefits and Your Cost Share” section
- Routine Services associated with Medicare-approved clinical trials as described under “Services Associated with Clinical Trials” in the “Benefits and Your Cost Share” section

Term of this EOC

This *EOC* is for the period January 1, 2021, through December 31, 2021, unless amended. Benefits, Copayments, and Coinsurance may change on January 1 of each year and at other times in accord with your Group’s *Agreement* with us. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has been amended.

Definitions

Some terms have special meaning in this *EOC*. When we use a term with special meaning in only one section of this *EOC*, we define it in that section. The terms in this “Definitions” section have special meaning when capitalized and used in any section of this *EOC*.

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable) and out-of-pocket maximums. The Accumulation Period for this *EOC* is from 1/1/21 through 12/31/21.

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

Catastrophic Coverage Stage: The stage in the Part D Drug Benefit where you pay a low Copayment or Coinsurance for your Part D drugs after you or other qualified parties on your behalf have spent \$6,550 in covered Part D drugs during the covered year. Note: This amount may change every January 1 in accord with Medicare requirements.

Centers for Medicare & Medicaid Services (CMS):

The federal agency that administers the Medicare program.

Ancillary Coverage: Optional benefits such as acupuncture, chiropractic, or dental coverage that may be available to Members enrolled under this *EOC*. If your plan includes Ancillary Coverage, this coverage will be described in an amendment to this *EOC* or a separate agreement from the issuer of the coverage.

Charges: “Charges” means the following:

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

Members, and the pharmacy program’s contribution to the net revenue requirements of Health Plan)

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

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service under this *EOC*.

Complaint: The formal name for “making a complaint” is “filing a grievance.” The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. See also “Grievance.”

Comprehensive Formulary (Formulary or “Drug List”): A list of Medicare Part D prescription drugs covered by our plan. The drugs on this list are selected by us with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Comprehensive Outpatient Rehabilitation Facility (CORF): A facility that mainly provides rehabilitation Services after an illness or injury, and provides a variety of Services, including physician’s Services, physical therapy, social or psychological Services, and outpatient rehabilitation.

Copayment: A specific dollar amount that you must pay when you receive a covered Service under this *EOC*. Note: The dollar amount of the Copayment can be \$0 (no charge).

Cost Share: The amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible.

Coverage Determination: An initial determination we make about whether a Part D drug prescribed for you is covered under Part D and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription for a Part D drug to a Plan Pharmacy and the pharmacy tells you the prescription isn’t covered by us, that isn’t a Coverage Determination. You need to call or write us to ask for a formal decision about the coverage. Coverage Determinations are called “coverage decisions” in this *EOC*.

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

Durable Medical Equipment (DME): Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

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

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

Emergency Services: Covered Services that are (1) rendered by a provider qualified to furnish Emergency Services; and (2) needed to treat, evaluate, or Stabilize an Emergency Medical Condition such as:

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

EOC: This *Evidence of Coverage* document, including any amendments, which describes the health care coverage of “Kaiser Permanente Senior Advantage (HMO) with Part D” under Health Plan’s *Agreement* with your Group.

Extra Help: A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Family: A Subscriber and all of their Dependents.

Grievance: A type of complaint you make about us, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

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

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. This *EOC* sometimes refers to Health Plan as “we” or “us.”

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

Initial Enrollment Period: When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you’re eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Income Related Monthly Adjustment Amount (IRMAA): If your modified adjusted gross income as reported on your IRS tax return from two years ago is above a certain amount, you’ll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

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

Medical Group: The Southern California Permanente Medical Group, a for-profit professional partnership.

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

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). A person enrolled in a Medicare Part D plan has Medicare

Part D by virtue of his or her enrollment in the Part D plan (this *EOC* is for a Part D plan).

Medicare Advantage Organization: A public or private entity organized and licensed by a state as a risk-bearing entity that has a contract with the Centers for Medicare & Medicaid Services to provide Services covered by Medicare, except for hospice care covered by Original Medicare. Kaiser Foundation Health Plan, Inc., is a Medicare Advantage Organization.

Medicare Advantage Plan: Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. Medicare Advantage Plans may also offer Medicare Part D (prescription drug coverage). This *EOC* is for a Medicare Part D plan.

Medicare Health Plan: A Medicare Health Plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage plans, Medicare Cost plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medigap (Medicare Supplement Insurance) Policy: Medicare supplement insurance sold by private insurance companies to fill “gaps” in the Original Medicare plan coverage. Medigap policies only work with the Original Medicare plan. (A Medicare Advantage Plan is not a Medigap policy.)

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

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

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

Non-Plan Pharmacy: A pharmacy other than a Plan Pharmacy. These pharmacies are also called “out-of-network pharmacies.”

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

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

Non-Plan Psychiatrist: A psychiatrist who is not a Plan Physician.

Non-Plan Skilled Nursing Facility: A Skilled Nursing Facility other than a Plan Skilled Nursing Facility.

Organization Determination: An initial determination we make about whether we will cover or pay for Services that you believe you should receive. We also make an Organization Determination when we provide you with Services, or refer you to a Non-Plan Provider for Services. Organization Determinations are called “coverage decisions” in this *EOC*.

Original Medicare (“Traditional Medicare” or “Fee-for-Service Medicare”): The Original Medicare plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay a deductible. Medicare pays its share of the Medicare approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance), and is available everywhere in the United States and its territories.

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your health resulting from an unforeseen illness or an unforeseen injury if all of the following are true:

- You are temporarily outside our Service Area
- A reasonable person would have believed that your health would seriously deteriorate if you delayed treatment until you returned to our Service Area

Physician Specialist Visits: Consultations, evaluations, and treatment by physician specialists, including personal Plan Physicians who are not Primary Care Physicians.

Plan Deductible: The amount you must pay under this *EOC* in the calendar year for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that calendar year. Please refer to the “Benefits and Your Cost Share” section to learn whether your coverage includes a Plan Deductible, the Services that are subject to the Plan Deductible, and the Plan Deductible amount.

Plan Facility: Any facility listed in the Provider Directory on our website at kp.org/facilities. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

Plan Hospital: Any hospital listed in the Provider Directory on our website at kp.org/facilities. In the

directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call our Member Service Contact Center.

Plan Medical Office: Any medical office listed in the Provider Directory on our website at kp.org/facilities. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The directory is updated periodically. The availability of Plan Medical Offices may change. If you have questions, please call our Member Service Contact Center.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Refer to the Provider Directory on our website at kp.org/facilities for locations of Plan Optical Sales Offices. In the directory, Plan Optical Sales Offices may be called “Vision Essentials.” The directory is updated periodically. The availability of Plan Optical Sales Offices may change. If you have questions, please call our Member Service Contact Center.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay under this *EOC* in the calendar year for certain covered Services that you receive in the same calendar year. Please refer to the “Benefits and Your Cost Share” section to find your Plan Out-of-Pocket Maximum amount and to learn which Services apply to the Plan Out-of-Pocket Maximum.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the Provider Directory on our website at kp.org/facilities for locations of Plan Pharmacies. The directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call our Member Service Contact Center.

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

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

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

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

receive in a hospital (including the Emergency Department) after your treating physician determines that this condition is Stabilized.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *EOC*.

Preventive Services: Covered Services that prevent or detect illness and do one or more of the following:

- Protect against disease and disability or further progression of a disease
- Detect disease in its earliest stages before noticeable symptoms develop

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Refer to the Provider Directory on our website at kp.org for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call our Member Service Contact Center.

Primary Care Visits: Evaluations and treatment provided by Primary Care Physicians and primary care Plan Providers who are not physicians (such as nurse practitioners).

Provider Directory: A directory of Plan Physicians and Plan Facilities in your Home Region. This directory is available on our website at kp.org/directory. To obtain a printed copy, call our Member Service Contact Center. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently the District of Columbia and parts of Northern California, Southern California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at kp.org or call our Member Service Contact Center.

Serious Emotional Disturbance of a Child Under Age 18: A condition identified as a “mental disorder” in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child’s age according to expected developmental norms, if the child also meets at least one of the following three criteria:

- As a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
- The child displays psychotic features, or risk of suicide or violence due to a mental disorder
- The child meets special education eligibility requirements under Section 5600.3(a)(2)(C) of the Welfare and Institutions Code

Service Area: The geographic area approved by the Centers for Medicare & Medicaid Services within which an eligible person may enroll in Senior Advantage. Note: Subject to approval by the Centers for Medicare & Medicaid Services, we may reduce or expand our Service Area effective any January 1. ZIP codes are subject to change by the U.S. Postal Service. The ZIP codes below for each county are in our Service Area:

- The following ZIP codes in Kern County are inside our Service Area: 93203, 93205–06, 93215–16, 93220, 93222, 93224–26, 93238, 93240–41, 93243, 93249–52, 93263, 93268, 93276, 93280, 93285, 93287, 93301–09, 93311–14, 93380, 93383–90, 93501–02, 93504–05, 93518–19, 93531, 93536, 93560–61, 93581
- The following ZIP codes in Los Angeles County are inside our Service Area: 90001–84, 90086–91, 90093–96, 90099, 90134, 90189, 90201–02, 90209–13, 90220–24, 90230–33, 90239–42, 90245, 90247–51, 90254–55, 90260–67, 90270, 90272, 90274–75, 90277–78, 90280, 90290–96, 90301–12, 90401–11, 90501–10, 90601–10, 90623, 90630–31, 90637–40, 90650–52, 90660–62, 90670–71, 90701–03, 90706–07, 90710–17, 90723, 90731–34, 90744–49, 90755, 90801–10, 90813–15, 90822, 90831–35, 90840, 90842, 90844, 90846–48, 90853, 90895, 90899, 91001, 91003, 91006–12, 91016–17, 91020–21, 91023–25, 91030–31, 91040–43, 91046, 91066, 91077, 91101–10, 91114–18, 91121, 91123–26, 91129, 91182, 91184–85, 91188–89, 91199, 91201–10, 91214, 91221–22, 91224–26, 91301–11, 91313, 91316, 91321–22, 91324–31, 91333–35, 91337, 91340–46, 91350–57, 91361–62, 91364–65, 91367, 91371–72, 91376, 91380–87, 91390, 91392–96, 91401–13, 91416, 91423, 91426, 91436, 91470, 91482, 91495–96, 91499, 91501–08, 91510, 91521–23, 91526, 91601–12, 91614–18, 91702, 91706, 91711, 91714–16, 91722–24, 91731–35, 91740–41, 91744–50, 91754–56, 91759, 91765–73, 91775–76, 91778, 91780, 91788–93, 91801–04, 91896, 91899, 93243, 93510, 93532, 93534–36, 93539, 93543–44, 93550–53, 93560, 93563, 93584, 93586, 93590–91, 93599
- All ZIP codes in Orange County are inside our Service Area: 90620–24, 90630–33, 90638, 90680, 90720–21, 90740, 90742–43, 92602–07, 92609–10, 92612, 92614–20, 92623–30, 92637, 92646–63, 92672–79, 92683–85, 92688, 92690–94, 92697–98, 92701–08, 92711–12, 92728, 92735, 92780–82, 92799, 92801–09, 92811–12, 92814–17, 92821–23, 92825, 92831–38, 92840–46, 92850, 92856–57, 92859, 92861–71, 92885–87, 92899
- The following ZIP codes in Riverside County are inside our Service Area: 91752, 92201–03, 92210–11, 92220, 92223, 92230, 92234–36, 92240–41, 92247–48, 92253, 92255, 92258, 92260–64, 92270, 92276, 92282, 92320, 92324, 92373, 92399, 92501–09, 92513–14, 92516–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92589–93, 92595–96, 92599, 92860, 92877–83
- The following ZIP codes in San Bernardino County are inside our Service Area: 91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758–59, 91761–64, 91766, 91784–86, 91792, 92305, 92307–08, 92313–18, 92321–22, 92324–25, 92329, 92331, 92333–37, 92339–41, 92344–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–95, 92397, 92399, 92401–08, 92410–11, 92413, 92415, 92418, 92423, 92427, 92880
- The following ZIP codes in San Diego County are inside our Service Area: 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–46, 91950–51, 91962–63, 91976–80, 91987, 92003, 92007–11, 92013–14, 92018–30, 92033, 92037–40, 92046, 92049, 92051–52, 92054–61, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92081–86, 92088, 92091–93, 92096, 92101–24, 92126–32, 92134–40, 92142–43, 92145, 92147, 92149–50, 92152–55, 92158–61, 92163, 92165–79, 92182, 92186–87, 92191–93, 92195–99
- The following ZIP codes in Ventura County are inside our Service Area: 90265, 91304, 91307, 91311, 91319–20, 91358–62, 91377, 93001–07, 93009–12, 93015–16, 93020–22, 93030–36, 93040–44, 93060–66, 93094, 93099, 93252

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

county. If you have a question about whether a ZIP code is in our Service Area, please call our Member Service Contact Center. Also, the ZIP codes listed above may include ZIP codes for Post Office boxes and commercial rental mailboxes. A Post Office box or rental mailbox cannot be used to determine whether you meet the residence eligibility requirements for Senior Advantage. Your permanent residence address must be used to determine your Senior Advantage eligibility.

Services: Health care services or items (“health care” includes both physical health care and mental health care) and services to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness.

Severe Mental Illness: The following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa.

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

Spouse: The person to whom the Subscriber is legally married under applicable law. For the purposes of this EOC, the term “Spouse” includes the Subscriber’s domestic partner. “Domestic partners” are two people who are registered and legally recognized as domestic partners by California (if your Group allows enrollment of domestic partners not legally recognized as domestic partners by California, “Spouse” also includes the Subscriber’s domestic partner who meets your Group’s eligibility requirements for domestic partners).

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

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

Telehealth Visits: Interactive video visits and scheduled telephone visits between you and your provider.

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

Premiums, Eligibility, and Enrollment

Premiums

Your Group is responsible for paying Premiums. If you are responsible for any contribution to the Premiums that your Group pays, your Group will tell you the amount, when Premiums are effective, and how to pay your Group. In addition to any amount you must pay your Group, you must also continue to pay Medicare your monthly Medicare premium.

If you do not have Medicare Part A, you may be eligible to purchase Medicare Part A from Social Security. Please contact Social Security for more information. If you get Medicare Part A, this may reduce the amount you would be expected to pay to your Group, please check with your Group’s benefits administrator.

Medicare Premiums

Medicare Part D premium due to income

If your modified adjusted gross income as reported on your IRS tax return from two years ago is above a certain amount, you’ll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn’t enough to cover the extra amount owed. If your benefit check isn’t enough to cover the extra amount, you will get a bill from Medicare. The extra amount must

be paid separately and cannot be paid with your monthly plan premium.

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact the Social Security Office at **1-800-772-1213** (TTY users call **1-800-325-0778**), 7 a.m. to 7 p.m., Monday through Friday.

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from Kaiser Permanente Senior Advantage and lose Part D prescription drug coverage.

Medicare Part D late enrollment penalty

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a Part D late enrollment penalty if at any time after your Initial Enrollment Period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. “Creditable prescription drug coverage” is coverage that meets Medicare’s minimum standards since it is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your Initial Enrollment Period or how many full calendar months you went without creditable prescription drug coverage (this *EOC* is for a Part D plan). You will have to pay this penalty for as long as you have Part D coverage. Your Group will inform you if the penalty applies to you.

If you disagree with your Part D late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call our Member Service Contact Center at the number on the front of this booklet to find out more about how to do this.

Note: If you receive Extra Help from Medicare to pay for your Part D prescription drugs, you will not pay a late enrollment penalty.

Medicare’s “Extra Help” Program

Medicare provides “Extra Help” to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan’s monthly premium, and prescription Copayments. This “Extra Help” also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for “Extra Help.” Some people automatically qualify for “Extra Help” and don’t need to apply. Medicare mails a letter to people who automatically qualify for “Extra Help.”

You may be able to get “Extra Help” to pay for your prescription drug premiums and costs. To see if you qualify for getting “Extra Help,” call:

- **1-800-MEDICARE (1-800-633-4227)** (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week;
- The Social Security Office at **1-800-772-1213** (TTY users call **1-800-325-0778**), 7 a.m. to 7 p.m., Monday through Friday (applications); or
- Your state Medicaid office (applications). See the “Important Phone Numbers and Resources” section for contact information

If you qualify for “Extra Help,” we will send you an *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low Income Subsidy Rider* or the *LIS Rider*), that explains your costs as a Member of our plan. If the amount of your “Extra Help” changes during the year, we will also mail you an updated *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*.

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this “Who Is Eligible” section, including your Group’s eligibility requirements and our Service Area eligibility requirements.

Group eligibility requirements

You must meet your Group’s eligibility requirements. Your Group is required to inform Subscribers of its eligibility requirements.

Senior Advantage eligibility requirements

- You must have Medicare Part B
- You must be a United States citizen or lawfully present in the United States
- Your Medicare coverage must be primary and your Group’s health care plan must be secondary
- You may not be enrolled in another Medicare Health Plan or Medicare prescription drug plan

Note: If you are enrolled in a Medicare plan and lose Medicare eligibility, you may be able to enroll under

your Group’s non-Medicare plan *if* that is permitted by your Group (please ask your Group for details).

Service Area eligibility requirements

You must live in our Service Area, unless you have been continuously enrolled in Senior Advantage since December 31, 1998, and lived outside our Service Area during that entire time. In which case, you may continue your membership unless you move and are still outside our Service Area. The “Definitions” section describes our Service Area and how it may change.

Moving outside our Service Area. If you permanently move outside our Service Area, or you are temporarily absent from our Service Area for a period of more than six months in a row, you must notify us and you cannot continue your Senior Advantage membership under this *EOC*.

Send your notice to:

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 232407
San Diego, CA 92193

It is in your best interest to notify us as soon as possible because until your Senior Advantage coverage is officially terminated by the Centers for Medicare & Medicaid Services, you will not be covered by us or Original Medicare for any care you receive from Non-Plan Providers, except as described in the sections listed below for the following Services:

- Authorized referrals as described under “Getting a Referral” in the “How to Obtain Services” section
- Certain care when you visit the service area of another Region as described under “Receiving Care Outside of Your Home Region” in the “How to Obtain Services” section
- Emergency ambulance Services as described under “Ambulance Services” in the “Benefits and Your Cost Share” section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the “Emergency Services and Urgent Care” section
- Out-of-area dialysis care as described under “Dialysis Care” in the “Benefits and Your Cost Share” section
- Prescription drugs from Non-Plan Pharmacies as described under “Outpatient Prescription Drugs, Supplies, and Supplements” in the “Benefits and Your Cost Share” section

- Routine Services associated with Medicare-approved clinical trials as described under “Services Associated with Clinical Trials” in the “Benefits and Your Cost Share” section

If you are not eligible to continue enrollment because you move to the service area of another Region, please contact your Group to learn about your Group health care options. You may be able to enroll in the service area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*.

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

Eligibility as a Subscriber

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

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

Eligibility as a Dependent

Dependent eligibility is subject to your Group’s eligibility requirements, which are not described in this *EOC*. You can obtain your Group’s eligibility requirements directly from your Group. If you are a Subscriber enrolled under this *EOC* or a subscriber enrolled in a non-Medicare plan offered by your Group, the following persons may be eligible to enroll as your Dependents under this *EOC* if they meet all of the other requirements described under “Group eligibility requirements,” “Senior Advantage eligibility requirements,” and “Service Area eligibility requirements” in this “Who Is Eligible” section:

- Your Spouse
- Your or your Spouse’s Dependent children, who are under age 26, if they are any of the following:
 - ◆ sons, daughters, or stepchildren
 - ◆ adopted children
 - ◆ children placed with you for adoption, but not including children placed with you for foster care
 - ◆ children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)
- Children whose parent is a Dependent under your family coverage (including adopted children and

children placed with your Dependent for adoption, but not including children placed with your Dependent for foster care) if they meet all of the following requirements:

- ◆ they are not married and do not have a domestic partner (for the purposes of this requirement only, “domestic partner” means someone who is registered and legally recognized as a domestic partner by California)
- ◆ they are under age 26
- ◆ they receive all of their support and maintenance from you or your Spouse
- ◆ they permanently reside with you or your Spouse
- Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption, but not including children placed with you for foster care) who reach the age limit may continue coverage under this *EOC* if all of the following conditions are met:
 - ◆ they meet all requirements to be a Dependent except for the age limit
 - ◆ your Group permits enrollment of Dependents
 - ◆ they are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
 - ◆ they receive 50 percent or more of their support and maintenance from you or your Spouse
 - ◆ you give us proof of their incapacity and dependency within 60 days after we request it (see “Disabled Dependent certification” below in this “Eligibility as a Dependent” section)

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

- If the child is a Member, we will send the Subscriber a notice of the Dependent’s membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent’s membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent’s incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as a disabled dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that the

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

- If the child is not a Member because you are changing coverage, you must give us proof, within 60 days after we request it, of the child’s incapacity and dependency as well as proof of the child’s coverage under your prior coverage. In the future, you must provide proof of the child’s continued incapacity and dependency within 60 days after you receive our request, but not more frequently than annually

Dependents not eligible to enroll under a Senior Advantage plan. If you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this *EOC*, you may be able to enroll them as your dependents under a non-Medicare plan offered by your Group. Please contact your Group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

How to 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, which allow enrollment in other situations
- The effective date of your Senior Advantage coverage under this *EOC* must be confirmed by the Centers for Medicare & Medicaid Services, as described under “Effective date of Senior Advantage coverage” in this “How to Enroll and When Coverage Begins” section

If you are a Subscriber under this *EOC* and you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this

EOC, you may be able to enroll them as your dependents under a non-Medicare plan offered by your Group. Please contact your Group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

If you are eligible to be a Dependent under this *EOC* but the subscriber in your family is enrolled under a non-Medicare plan offered by your Group, the subscriber must follow the rules applicable to Subscribers who are enrolling Dependents in this “How to Enroll and When Coverage Begins” section.

Effective date of Senior Advantage coverage

After we receive your completed Senior Advantage Election Form, we will submit your enrollment request to the Centers for Medicare & Medicaid Services for confirmation and send you a notice indicating the proposed effective date of your Senior Advantage coverage under this *EOC*.

If the Centers for Medicare & Medicaid Services confirms your Senior Advantage enrollment and effective date, we will send you a notice that confirms your enrollment and effective date. If the Centers for Medicare & Medicaid Services tells us that you do not have Medicare Part B coverage, we will notify you that you will be disenrolled from Senior Advantage.

New employees

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

Effective date of Senior Advantage coverage. The effective date of Senior Advantage coverage for new employees and their eligible family Dependents or newly acquired Dependents, is determined by your Group, subject to confirmation by the Centers for Medicare & Medicaid Services.

Group open enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person to your Group during your Group’s open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage, which is subject to confirmation by the Centers for Medicare & Medicaid Services.

Special enrollment

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

- You become eligible because you experience a qualifying event (sometimes called a “triggering event”) 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. Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, from the Subscriber

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

Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application, and a Senior Advantage Election Form for each person, from the Subscriber. Subject to confirmation by the Centers for Medicare & Medicaid Services, enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, date of adoption, or the date you or your Spouse have newly assumed a legal right to control health care in anticipation of 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 they 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 coverage through Covered California, Medicaid coverage (known as Medi-Cal in California), Children's Health Insurance Program coverage, or Medi-Cal Access Program coverage
- ◆ reaching a lifetime maximum on all benefits

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

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for coverage through Covered California, Medicaid, Children's Health Insurance Program, or Medi-Cal Access Program coverage. Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application, and Senior Advantage Election Form for each person, from the Subscriber.

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

Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a

different effective date, the effective date cannot be earlier than 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, and a Senior Advantage Election Form for each person, 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
- Certain care when you visit the service area of another Region as described under "Receiving Care Outside of Your Home Region" in this "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Your Cost Share" section
- Prescription drugs from Non-Plan Pharmacies as described under "Outpatient Prescription Drugs,"

Supplies, and Supplements” in the “Benefits and Your Cost Share” section

- Routine Services associated with Medicare-approved clinical trials as described under “Services Associated with Clinical Trials” in the “Benefits and Your Cost Share” 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 this *EOC*.

Routine Care

To request a non-urgent appointment, you can call your local Plan Facility or request the appointment online. For appointment phone numbers, please refer to our Provider Directory or call our Member Service Contact Center. To request an appointment online, go to our website at **kp.org**.

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 phone number at a Plan Facility. For phone numbers, please refer to our Provider Directory or call our Member Service Contact Center.

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

Our Advice Nurses

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

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. However, if you choose a specialist who is not designated as a Primary Care Physician as your personal Plan Physician, the Cost Share for a Physician Specialist Visit will apply to all visits with the specialist except for Preventive Services listed in the “Benefits and Your Cost Share” section.

To learn how to select or change to a different personal Plan Physician, visit our website at **kp.org**, or call our Member Service Contact Center. Refer to our Provider Directory for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call our Member Service Contact Center. You can change your personal Plan Physician at any time 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, dermatology, and physical, occupational, and speech therapies. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, mental health Services, substance use disorder treatment, and obstetrics/gynecology

A Plan Physician must refer you before you can get care from a specialist in urology except that you do not need a referral to receive Services related to sexual or reproductive health, such as a vasectomy.

Although a referral or prior authorization is not required to receive most care from these providers, a referral may be required in the following situations:

- 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
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

If a Plan Physician refers you to a specialist, the referral will be for a specific treatment plan. Your treatment plan may include a standing referral if ongoing care from the specialist is prescribed. For example, if you have a life-threatening, degenerative, or disabling condition, you can get a standing referral to a specialist if ongoing care from the specialist is required.

Medical Group authorization procedure for certain referrals

The following are examples of Services that 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
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management (UM) is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at kp.org/UM or call our Member Service Contact Center to request a printed copy. 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.

Additional information about prior authorization for durable medical equipment, ostomy, urological, and wound care supplies. The prior authorization process for durable medical equipment, ostomy, urological, and wound care supplies includes the use of formulary guidelines. These guidelines were developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with clinical expertise. The formulary guidelines are periodically updated to keep pace with changes in medical technology, Medicare guidelines, and clinical practice.

If your Plan Physician prescribes one of these items, they will submit a written referral in accord with the UM process described in this “Medical Group authorization procedure for certain referrals” section. If the formulary guidelines do not specify that the prescribed item is appropriate for your medical condition, the referral will be submitted to the Medical Group’s designee Plan Physician, who will make an authorization decision as described under “Medical Group’s decision time frames” in this “Medical Group authorization procedure for certain referrals” section.

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. 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.

If the Medical Group does not authorize all of the Services requested and you want to appeal the decision, you can file a grievance as described in the “Coverage Decisions, Appeals, and Complaints” section.

Your Cost Share. For these referral Services, you pay **the Cost Share required for Services provided by a Plan Provider** as described in this *EOC*.

Travel and lodging for certain referrals

The following are examples of when we will arrange or provide reimbursement for certain travel and lodging expenses in accord with our Travel and Lodging Program Description:

- If Medical Group refers you to a provider that is more than 50 miles from where you live for certain specialty Services such as bariatric surgery, complex thoracic surgery, transplant nephrectomy, or inpatient chemotherapy for leukemia and lymphoma
- If Medical Group refers you to a provider that is outside our Service Area for certain specialty Services such as a transplant or transgender surgery

For the complete list of specialty Services for which we will arrange or provide reimbursement for travel and lodging expenses, the amount of reimbursement, limitations and exclusions, and how to request reimbursement, please refer to the Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at kp.org/specialty-care/travel-reimbursements or by calling our Member Service Contact Center.

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an appropriately qualified medical professional for your condition. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with a Non-Plan Physician for a second opinion. For purposes of this “Second Opinions” provision, an “appropriately qualified medical professional” is a physician who is acting within their scope of practice and who possesses a clinical background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion.

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

- 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
- An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial and of your right to file a grievance as described in the “Coverage Decisions, Appeals, and Complaints” section.

Your Cost Share. For these referral Services, you pay **the Cost Share required for Services provided by a Plan Provider** as described in this *EOC*.

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 visit our website at kp.org or call our Member Service Contact Center.

Financial liability

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

Your Cost Share. When you are referred to a Plan Provider for covered Services, you pay **the Cost Share required for Services from that provider** as described in this *EOC*.

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

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

Completion of Services. If you are undergoing treatment for specific conditions from a Plan Physician (or certain other providers) when the contract with him or her ends (for reasons other than medical disciplinary cause, criminal activity, or the provider's voluntary termination), you may be eligible to continue receiving covered care from the terminated provider for your condition. The conditions that are subject to this continuation of care provision are:

- Certain conditions that are either acute, or serious and chronic. We may cover these Services for up to 90 days, or longer, if necessary for a safe transfer of care to a Plan Physician or other contracting provider as determined by the Medical Group
- A high-risk pregnancy or a pregnancy in its second or third trimester. We may cover these Services through postpartum care related to the delivery, or longer if Medically Necessary for a safe transfer of care to a Plan Physician as determined by the Medical Group

The Services must be otherwise covered under this *EOC*. Also, the terminated provider must agree in writing to our contractual terms and conditions and comply with them for Services to be covered by us.

Your Cost Share. For the Services of a terminated provider, you pay **the Cost Share required for Services provided by a Plan Provider** as described in this *EOC*.

More information. For more information about this provision, or to request the Services, please call our Member Service Contact Center.

Receiving Care Outside of Your Home Region

If you have questions about your coverage when you are away from home, call the Away from Home Travel line at **1-951-268-3900** 24 hours a day, seven days a week (except closed holidays). For example, call this number for the following concerns:

- What you should do to prepare for your trip
- What Services are covered when you are outside our Service Area

- How to get care in another Region
- How to request reimbursement if you paid for covered Services outside our Service Area

You can also get information on our website at **kp.org/travel**.

Receiving Care in the Service Area of another Region

If you visit the service area of another Region temporarily, you can receive certain care covered under this *EOC* from designated providers in that service area.

Please call our Member Service Contact Center or our away from home travel line at **1-951-268-3900** (TTY users call **711**), 24 hours a day, seven days a week except holidays, for more information about getting care when visiting another Kaiser Permanente Region's service area, including coverage information and facility locations in the service area of another Region.

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 Contact 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 they receive. If you let someone else use your ID card, we may keep your ID card and terminate your membership as described under "Termination for Cause" in the "Termination of Membership" section.

Your Medicare card

Do NOT use your red, white, and blue Medicare card for covered medical Services while you are a Member of this plan. If you use your Medicare card instead of your Senior Advantage membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospice services or participate in routine research studies.

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

Member Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain the following:

- Your Health Plan benefits
- How to make your first medical appointment
- What to do if you move
- How to replace your Kaiser Permanente ID card

Many 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 Contact Center representatives are available to assist you seven days a week from 8 a.m. to 8 p.m. toll free at **1-800-443-0815** or **711** (TTY for the deaf, hard of hearing, or speech impaired). For your convenience, you can also contact us through our website at **kp.org**.

Cost Share estimates

For information about estimates, see “Getting an estimate of your Cost Share” under “Your Cost Share” in the “Benefits and Your Cost Share” section.

Plan Facilities

Plan Medical Offices and Plan Hospitals are listed in the Provider Directory for your Home Region. The directory describes the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services. This directory is available on our website at **kp.org/facilities**. To obtain a printed copy, call our Member Service Contact Center. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

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 (for Emergency Department locations, refer to our Provider Directory or call our Member Service Contact Center)
- Same-day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call our Member Service Contact Center)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (for locations, refer to our Provider Directory or call our Member Service Contact Center)
- Plan Pharmacies are located at most Plan Medical Offices (refer to *Kaiser Permanente Pharmacy Directory* for pharmacy locations)

Provider Directory

The *Provider Directory* lists our Plan Providers. It is subject to change and periodically updated. If you don't have our *Provider Directory*, you can get a copy by calling our Member Service Contact Center or by visiting our website at **kp.org/directory**.

Pharmacy Directory

The *Kaiser Permanente Pharmacy Directory* lists the locations of Plan Pharmacies, which are also called “network pharmacies.” The pharmacy directory provides additional information about obtaining prescription drugs. It is subject to change and periodically updated. If you don't have the *Kaiser Permanente Pharmacy Directory*, you can get a copy by calling our Member Service Contact Center or by visiting our website at **kp.org/directory**.

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.

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 in a hospital (including the Emergency Department) after your treating physician determines that your condition is Stabilized.

To request prior authorization, the Non-Plan Provider must call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non-Plan Provider. If we determine that you require Post-Stabilization Care and that this care is part of your covered benefits, we will authorize your care from the Non-Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care with the treating physician's concurrence. 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. If you receive care from a Non-Plan Provider that we have not authorized, you may have to pay the full cost of that care if you are notified by the Non-Plan Provider or us about your potential liability.

Your Cost Share

Your Cost Share for covered Emergency Services and Post-Stabilization Care is described in the "Benefits and Your Cost Share" section. Your Cost Share is the same whether you receive the Services from a Plan Provider or a Non-Plan Provider. For example:

- If you receive Emergency Services in the Emergency Department of a Non-Plan Hospital, you pay the Cost Share for an Emergency Department visit as described under "Outpatient Care"
- If we gave prior authorization for inpatient Post-Stabilization Care in a Non-Plan Hospital, you pay the Cost Share for hospital inpatient care as described under "Hospital Inpatient Care"

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 number at a Plan Facility. For appointment and advice phone numbers, refer to our Provider Directory or call our Member Service Contact Center.

In the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC* (such as a major disaster, epidemic, war, riot, and civil insurrection), we cover Urgent Care inside our Service Area from a Non-Plan Provider.

Out-of-Area Urgent Care

If you need Urgent Care due to an unforeseen illness or unforeseen injury, we cover Medically Necessary Services to prevent serious deterioration of your 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
- A reasonable person would have believed that your 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 if the Services would have been covered under this *EOC* if you had received them from Plan Providers.

We do not cover follow-up care from Non-Plan Providers after you no longer need Urgent Care. To obtain follow-up care from a Plan Provider, call the appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call our Member Service Contact Center.

Your Cost Share

Your Cost Share for covered Urgent Care is the Cost Share required for Services provided by Plan Providers as described in this *EOC*. For example:

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non-Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described under "Outpatient Care"
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described under "Outpatient Imaging, Laboratory, and

Other Diagnostic and Treatment Services” in addition to the Cost Share for the Urgent Care evaluation

- Note: If you receive Urgent Care in an Emergency Department, you pay the Cost Share for an Emergency Department visit as described under “Outpatient Care.”

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or 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 Your Cost Share” section, ask the Non-Plan Provider to submit a claim to us within 60 days or as soon as possible, but no later than 15 months after receiving the care (or up to 27 months according to Medicare rules, in some cases). If the provider refuses to bill us, send us the unpaid bill with a claim form. Also, if you receive Services from a Plan Provider that are prescribed by a Non-Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Urgent Care (for example, drugs), you may be required to pay for the Services and file a claim. To request payment or reimbursement, you must file a claim as described in the “Requests for Payment” section.

We will reduce any payment we make to you or the Non-Plan Provider by the applicable Cost Share. Also, in accord with applicable law, we will reduce our payment by any amounts paid or payable (or that in the absence of this plan would have been payable) for the Services under any insurance policy, or any other contract or coverage, or any government program except Medicaid.

Benefits and Your Cost Share

- This section describes the Services that are covered under this *EOC*.
- Services are covered under this *EOC* as specifically described in this *EOC*. Services that are not specifically described in this *EOC* are not covered, except as required by federal law. Services are subject to exclusions and limitations described in the “Exclusions, Limitations, Coordination of Benefits, and Reductions” section. Except as otherwise described in this *EOC*, all of the following conditions must be 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:
 - ◆ Preventive Services
 - ◆ health care items and services for diagnosis, assessment, or treatment
 - ◆ health education covered under “Health Education” in this “Benefits and Your Cost Share” section
 - ◆ other health care items and services
 - ◆ other services to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except for:
 - ◆ certain care when you visit the service area of another Region, as described under “Receiving Care Outside of Your Home Region” in the “How to Obtain Services” section
 - ◆ drugs prescribed by dentists, as described under “Outpatient Prescription Drugs, Supplies, and Supplements” in this “Benefits and Your Cost Share” section
 - ◆ emergency ambulance Services, as described under “Ambulance Services” in this “Benefits and Your Cost Share” section
 - ◆ Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the “Emergency Services and Urgent Care” section
 - ◆ eyeglasses and contact lenses prescribed by Non-Plan Providers, as described under “Vision Services” in this “Benefits and Your Cost Share” section
 - ◆ out-of-area dialysis care, as described under “Dialysis Care” in this “Benefits and Your Cost Share” section
 - ◆ routine Services associated with Medicare-approved clinical trials, as described under “Services Associated with Clinical Trials” in this “Benefits and Your Cost Share” section
- You receive the Services from Plan Providers inside our Service Area, except for:
 - ◆ authorized referrals, as described under “Getting a Referral” in the “How to Obtain Services” section
 - ◆ certain care when you visit the service area of another Region, as described under “Receiving Care Outside of Your Home Region” in the “How to Obtain Services” section

- ◆ emergency ambulance Services, as described under “Ambulance Services” in this “Benefits and Your Cost Share” section
- ◆ Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the “Emergency Services and Urgent Care” section
- ◆ out-of-area dialysis care, as described under “Dialysis Care” in this “Benefits and Your Cost Share” section
- ◆ prescription drugs from Non-Plan Pharmacies, as described under “Outpatient Prescription Drugs, Supplies, and Supplements” in this “Benefits and Your Cost Share” section
- ◆ routine Services associated with Medicare-approved clinical trials, as described under “Services Associated with Clinical Trials” in this “Benefits and Your Cost Share” section
- The Medical Group has given prior authorization for the Services, if required, as described under “Medical Group authorization procedure for certain referrals” in the “How to Obtain Services” section

Please also 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
- Our Provider Directory for the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services

Your Cost Share

Your Cost Share is the amount you are required to pay for covered Services. The Cost Share for covered Services is listed in this *EOC*. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible.

Cost Share during COVID-19 pandemic

If you live in a geographic area that is subject to a public health emergency declaration, you will not have to pay Cost Share related to COVID-19 testing or treatment for the duration of the public health emergency.

General rules, examples, and exceptions

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

- If you are receiving covered inpatient hospital Services on the effective date of this *EOC*, you pay the Cost Share 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 Share in effect on the date you receive the Services
- For items ordered in advance, you pay the Cost Share 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 Share 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

Payment toward your Cost Share (and when you may be billed). In most cases, your provider will ask you to make a payment toward your Cost Share at the time you receive Services. If you receive more than one type of Services (such as primary care treatment and laboratory tests), you may be required to pay separate Cost Share for each of those Services. Keep in mind that your payment toward your Cost Share may cover only a portion of your total Cost Share for the Services you receive, and you will be billed for any additional amounts that are due. The following are examples of when you may be asked to pay (or you may be billed for) Cost Share amounts in addition to the amount you pay at check-in:

- You receive non-preventive Services during a preventive visit. For example, you go in for a routine physical exam, and at check-in you pay your Cost Share for the preventive exam (your Cost Share may be “no charge”). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional non-preventive diagnostic Services

- You receive diagnostic Services during a treatment visit. For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem with your health and performs or orders diagnostic Services (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional diagnostic Services
- You receive treatment Services during a diagnostic visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay (or you will be billed for) your Cost Share for these additional treatment Services
- You receive Services from a second provider during your visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay (or you will be billed for) your Cost Share for the consultation with the specialist

In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for your Cost Share (for example, some Laboratory Departments are not able to collect Cost Shares).

- When we send you a bill, it will list Charges for the Services you received, payments and credits applied to your account, and any amounts you still owe. Your current bill may not always reflect your most recent Charges and payments. Any Charges and payments that are not on the current bill will appear on a future bill. Sometimes, you may see a payment but not the related Charges for Services. That could be because your payment was recorded before the Charges for the Services were processed. If so, the Charges will appear on a future bill. Also, you may receive more than one bill for a single outpatient visit or inpatient stay. For example, you may receive a bill for physician services and a separate bill for hospital services. If you don't see all the Charges for Services on one bill, they will appear on a future bill. If we determine that you overpaid and are due a refund, then we will send a refund to you within four weeks after we make that determination. If you have questions about a bill, please call the phone number on the bill.

In some cases, a Non-Plan Provider may be involved in the provision of covered Services at a Plan Facility or a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the covered Services you receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Requests for Payment" section.

Primary Care Visits, Non-Physician Specialist Visits, and Physician Specialist Visits.

The Cost Share for a Primary Care Visit applies to evaluations and treatment provided by generalists in internal medicine, pediatrics, or family practice, and by specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Some physician specialists provide primary care in addition to specialty care but are not designated as Primary Care Physicians. If you receive Services from one of these specialists, the Cost Share for a Physician Specialist Visit will apply to all consultations, evaluations, and treatment provided by the specialist except for routine preventive counseling and exams listed under "Preventive Services" in this "Benefits and Your Cost Share" section. For example, if your personal Plan Physician is a specialist in internal medicine or obstetrics/gynecology who is not a Primary Care Physician, you will pay the Cost Share for a Physician Specialist Visit for all consultations, evaluations, and treatment by the specialist except routine preventive counseling and exams listed under "Preventive Services" in this "Benefits and Your Cost Share" section. The Non-Physician Specialist Visit Cost Share applies to consultations, evaluations, and treatment provided by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Noncovered Services. If you receive Services that are not covered under this *EOC*, you may have to pay the full price of those Services. Payments you make for noncovered Services do not apply to any deductible or out-of-pocket maximum.

Getting an estimate of your Cost Share

If you have questions about the Cost Share for specific Services that you expect to receive or that your provider orders during a visit or procedure, please visit our website at kp.org/memberestimates to use our cost estimate tool or call our Member Service Contact Center.

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan

Deductible, please call **1-800-390-3507** (TTY users call **711**) Monday through Friday, 7 a.m. to 7 p.m.

- For all other Cost Share estimates, please call **1-800-443-0815**, 8 a.m. to 8 p.m., seven days a week (TTY users should call **711**)

Cost Share estimates are based on your benefits and the Services you expect to receive. They are a prediction of cost and not a guarantee of the final cost of Services. Your final cost may be higher or lower than the estimate since not everything about your care can be known in advance.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service, after you meet any applicable deductible, is described in this *EOC*.

Note: If Charges for Services are less than the Copayment described in this *EOC*, you will pay the lesser amount.

Plan Out-of-Pocket Maximum

There is a limit to the total amount of Cost Share you must pay under this *EOC* in the calendar year for covered Services that you receive in the same calendar year. The Services that apply to the Plan Out-of-Pocket Maximum are described under the “Payments that count toward the Plan Out-of-Pocket Maximum” section below. The limit is:

- **\$1,700** per calendar year for any one Member

For Services subject to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share during the remainder of the calendar year, but every other Member in your Family must continue to pay Cost Share during the remainder of the calendar year until either he or she reaches the **\$1,700** maximum for any one Member.

Payments that count toward the Plan Out-of-Pocket Maximum. Any amounts you pay for the following Services apply toward the out-of-pocket maximum:

- Covered in-network Medicare Part A and Part B Services
- Medicare Part B drugs
- Residential treatment program Services covered in the “Substance Use Disorder Treatment” and “Mental Health Services” sections

Copayments and Coinsurance you pay for Services that are not described above, do not apply to the out-of-pocket maximum. For these Services, you must pay

Copayments or Coinsurance even if you have already reached the out-of-pocket maximum. In addition:

- If your plan includes supplemental chiropractic or acupuncture Services, or fitness benefit, described in an amendment to this *EOC*, those Services do not apply toward the maximum
- If your plan includes an Allowance for specific Services (such as eyeglasses, contact lenses, or hearing aids), any amounts you pay that exceed the Allowance do not apply toward the maximum

Outpatient Care

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

Office visits

- Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this *EOC*: **a \$20 Copayment per visit**
- Physician Specialist Visits that are not described elsewhere in this *EOC*: **a \$20 Copayment per visit**
- Outpatient visits that are available as group appointments that are not described elsewhere in this *EOC*: **a \$10 Copayment per visit**
- 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**
- Routine physical exams that are medically appropriate preventive care in accord with generally accepted professional standards of practice: **no charge**
- Family planning counseling, or internally implanted time-release contraceptives or intrauterine devices (IUDs) and office visits related to their administration and management: **a \$20 Copayment per visit**
- After confirmation of pregnancy, the normal series of regularly scheduled preventive prenatal care exams and the first postpartum follow-up consultation and exam: **a \$15 Copayment per visit**
- Voluntary termination of pregnancy: **a \$20 Copayment per procedure**
- Physical, occupational, and speech therapy in accord with Medicare guidelines: **a \$20 Copayment per visit**
- Group and individual physical therapy prescribed by a Plan Provider to prevent falls: **no charge**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-

treatment program in accord with Medicare guidelines: **a \$20 Copayment per day**

- Manual manipulation of the spine to correct subluxation, in accord with Medicare guidelines, is covered by a participating chiropractor of the American Specialty Health Plans of California, Inc. (ASH Plans): **a \$20 Copayment per visit**. (A referral by a Plan Physician is not required. For the list of participating ASH Plans providers, please refer to your *Provider Directory*)

Acupuncture Services

- Acupuncture for chronic low back pain up to 12 visits in 90 days, in accord with Medicare guidelines: **a \$20 Copayment per visit**. Chronic low back pain is defined as follows:
 - ◆ lasting 12 weeks or longer
 - ◆ non-specific, in that it has no identifiable systemic cause (i.e. not associated with metastatic, inflammatory, infectious, etc. disease)
 - ◆ not associated with surgery or pregnancy
- An additional eight sessions are covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing.
- Acupuncture not covered by Medicare (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain): **a \$20 Copayment per visit**

Emergency and Urgent Care visits

- Urgent Care consultations, evaluations, and treatment: **a \$20 Copayment per visit**
- Emergency Department visits: **a \$50 Copayment per visit**
- **If you are admitted from the Emergency Department.** If you are admitted to the hospital as an inpatient for covered Services (either within 24 hours for the same condition or after an observation stay), then the Services you received in the Emergency Department and observation stay, if applicable, will be considered part of your inpatient hospital stay. For the Cost Share for inpatient care, please refer to “Hospital Inpatient Care” in this “Benefits and Your Cost Share” section. However, the Emergency Department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient.

Outpatient surgeries and procedures

- Outpatient surgery and outpatient procedures when 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: **a \$175 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a \$20 Copayment per procedure**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this “Benefits and Your Cost Share” 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 Other Diagnostic and Treatment Services”)
- Pre- and post-operative visits:
 - ◆ Primary Care Visits and Non-Physician Specialist Visits: **a \$20 Copayment per visit**
 - ◆ Physician Specialist Visits: **a \$20 Copayment per visit**

Administered drugs and products

Administered drugs and products are medications and products that require administration or observation by medical personnel. We cover these items when prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility or during home visits.

We cover the following Services and their administration in a Plan Facility at the Cost Share indicated:

- Whole blood, red blood cells, plasma, and platelets: **no charge**
- Allergy antigens (including administration): **a \$3 Copayment per visit**
- Cancer chemotherapy drugs and adjuncts: **no charge**
- Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products (“biologics”) derived from tissue, cells, or blood: **no charge**
- Tuberculosis skin tests: **no charge**
- All other administered drugs and products: **no charge**

- We cover drugs and products administered to you during a home visit at **no charge**.

Certain administered drugs are Preventive Services. Please refer to “Preventive Services” for information on immunizations.

Note: Vaccines covered by Medicare Part D are not covered under this “Outpatient Care” section (instead, refer to “Outpatient Prescription Drugs, Supplies, and Supplements” in this “Benefits and Your Cost Share” section).

For Services related to “Outpatient Care,” refer to these sections

- Bariatric Surgery
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Durable Medical Equipment (“DME”) for Home Use
- Fertility Services
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Meals
- Mental Health Services
- Ostomy, Urological, and Wound Care Supplies
- Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services
- Outpatient Prescription Drugs, Supplies, and Supplements
- Preventive Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Substance Use Disorder Treatment
- Transplant Services
- Vision Services

Hospital Inpatient Care

We cover the following inpatient Services 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 Your Cost Share” section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and other diagnostic and treatment Services, including MRI, CT, and PET scans
- Whole blood, red blood cells, plasma, platelets, 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 Your Cost Share” section)
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program) in accord with Medicare guidelines
- Respiratory therapy
- Medical social services and discharge planning
- **Your Cost Share.** We cover hospital inpatient Services at a **\$500 Copayment per admission**.

For Services related to “Hospital Inpatient Care,” refer to these sections

The following types of inpatient Services are covered only as described under the following headings in this “Benefits and Your Cost Share” section:

- Bariatric Surgery
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Fertility Services
- Hospice Care
- Mental Health Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Religious Nonmedical Health Care Institution Services
- Services Associated with Clinical Trials
- Skilled Nursing Facility Care
- Substance Use Disorder Treatment
- Transplant Services

Ambulance Services

Emergency

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

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

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you are not responsible for any amounts beyond your Cost Share for covered emergency ambulance Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the “Requests for Payment” section.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance Services in accord with Medicare guidelines

if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance 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 and from qualifying locations as defined by Medicare guidelines.

Your Cost Share

You pay the following for covered ambulance Services:

- Emergency ambulance Services: **a \$125 Copayment per trip**
- Nonemergency Services: **a \$125 Copayment per trip**

Ambulance Services exclusion(s)

- Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), 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, other diagnostic and treatment Services, and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

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

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

For the following Services related to “Bariatric Surgery,” refer to these sections

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

Dental Services for Radiation Treatment and Dental Anesthesia

Dental Services for radiation treatment

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

Dental anesthesia

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

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

We do not cover any other Services related to the dental procedure, such as the dentist’s Services, unless the Service is covered in accord with Medicare guidelines.

Your Cost Share

You pay the following for dental Services covered under this “Dental Services for Radiation Treatment and Dental Anesthesia” section:

- Non-Physician Specialist Visits with dentists for Services covered under this “Dental Services for Radiation Treatment and Dental Anesthesia” section: **a \$20 Copayment per visit**
- Physician Specialist Visits for Services covered under this “Dental Services for Radiation Treatment and Dental Anesthesia” section: **a \$20 Copayment per visit**
- Outpatient surgery and outpatient procedures when 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: **a \$175 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a \$20 Copayment per procedure**

- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this “Benefits and Your Cost Share” 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 Other Diagnostic and Treatment Services”)
- Hospital inpatient care (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services): **a \$500 Copayment per admission**

For the following Services related to “Dental Services for Radiation Treatment and Dental Anesthesia,” refer to these sections

- Office visits not described in this “Dental Services for Radiation Treatment and Dental Anesthesia” section (refer to “Outpatient Care”)
- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to “Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services”)
- 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:

- You satisfy all medical criteria developed by the Medical Group
- The facility is certified by Medicare
- A Plan Physician provides a written referral for your dialysis treatment except for out-of-area dialysis care

We also cover hemodialysis and peritoneal home dialysis (including equipment, training, and medical supplies). 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.

Out-of-area dialysis care

We cover dialysis (kidney) Services that you get at a Medicare-certified dialysis facility when you are temporarily outside our Service Area. If possible, before

you leave the Service Area, please let us know where you are going so we can help arrange for you to have maintenance dialysis while outside our Service Area.

The procedure for obtaining reimbursement for out-of-area dialysis care is described in the “Requests for Payment” section.

Your Cost Share. You pay the following for these covered Services related to dialysis:

- Equipment and supplies for home hemodialysis and home peritoneal dialysis: **no charge**
- One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment: **no charge**
- Hemodialysis and peritoneal dialysis treatment: **no charge**
- Hospital inpatient care (including room and board, drugs, imaging, laboratory, and other diagnostic and treatment Services, and Plan Physician Services): **a \$500 Copayment per admission**

For the following Services related to “Dialysis Care,” refer to these sections

- Durable medical equipment for home use (refer to “Durable Medical Equipment (“DME”) for Home Use”)
- Hospital inpatient care (refer to “Hospital Inpatient Care”)
- Office visits not described in this “Dialysis Care” section (refer to “Outpatient Care”)
- Kidney disease education (refer to “Health Education”)
- Outpatient laboratory (refer to “Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services”)
- Outpatient prescription drugs (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)
- Outpatient administered drugs (refer to “Outpatient Care”)
- Telehealth Visits (refer to “Telehealth Visits”)

Dialysis care exclusion(s)

- 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 (“DME”) for Home Use

DME coverage rules

DME for home use is an item that meets the following criteria:

- The item is intended for repeated use
- The item is primarily and customarily used to serve a medical purpose
- The item is generally useful only to an individual with an illness or injury
- The item is appropriate for use in the home (or another location used as your home as defined by Medicare)

For a DME item to be covered, all of the following requirements must be met:

- Your *EOC* includes coverage for the requested DME item
- A Plan Physician has prescribed the DME item for your medical condition
- The item has been approved for you through the Plan’s prior authorization process, as described in “Medical Group authorization procedure for certain referrals” under “Getting a Referral” in the “How to Obtain Services” section
- The Services are provided inside our Service Area

Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor.

DME for diabetes

We cover the following diabetes blood-testing supplies and equipment and insulin-administration devices if all of the requirements described under “DME coverage rules” in this “Durable Medical Equipment (“DME”) for Home Use” section are met:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Insulin pumps and supplies to operate the pump
- **Your Cost Share.** You pay the following for covered DME for diabetes (including repair or replacement of covered equipment):
- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices): **no charge**

- Insulin pumps and supplies to operate the pump:
20 percent Coinsurance

Base DME Items

We cover Base DME Items (including repair or replacement of covered equipment) if all of the requirements described under “DME coverage rules” in this “Durable Medical Equipment (“DME”) for Home Use” section are met. “Base DME Items” means the following items:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Bone stimulator
- Canes (standard curved handle or quad) and replacement supplies
- Cervical traction (over door)
- Crutches (standard or forearm) and replacement supplies
- Dry pressure pad for a mattress
- Infusion pumps (such as insulin pumps) and supplies to operate the pump
- IV pole
- Nebulizer and supplies
- Phototherapy blankets for treatment of jaundice in newborns
- **Your Cost Share.** You pay the following for covered Base DME Items: **20 percent Coinsurance.**

Other covered DME items

- If all of the requirements described under “DME coverage rules” in this “Durable Medical Equipment (“DME”) for Home Use” section are met, we cover the following other DME items (including repair or replacement of covered equipment):
- Bed accessories for a hospital bed when bed extension is required
- Heel or elbow protectors to prevent or minimize advanced pressure relief equipment use
- Iontophoresis device to treat hyperhidrosis when antiperspirants are contraindicated and the hyperhidrosis has created medical complications (for example, skin infection) or preventing daily living activities
- Nontherapeutic continuous glucose monitoring devices and related supplies
- Peak flow meters

- Resuscitation bag if tracheostomy patient has significant secretion management problems, needing lavage and suction technique aided by deep breathing via resuscitation bag

- **Your Cost Share.** You pay the following for other covered DME items: **20 percent Coinsurance**, except peak flow meters are covered at: **no charge.**

Outside our Service Area

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

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
- Canes (standard curved handle)
- Crutches (standard)
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

For the following Services related to “Durable Medical Equipment (“DME”) for Home Use,” refer to these sections

- 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”)
- Insulin and any other drugs administered with an infusion pump (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)

DME for home use exclusion(s)

- Comfort, convenience, or luxury equipment or features
- Dental appliances
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including

devices intended to provide additional support for recreational or sports activities)

- Hygiene equipment
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car, unless covered in accord with Medicare guidelines
- 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
- Repair or replacement of equipment due to misuse

Fertility Services

“Fertility Services” means treatments and procedures to help you become pregnant.

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

Diagnosis and treatment of infertility

For purposes of this “Diagnosis and treatment of infertility” section, “infertility” means not being able to get pregnant or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or having a medical or other demonstrated condition that is recognized by a Plan Physician as a cause of infertility. We cover the following:

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

You pay the following for covered infertility Services:

- Office visits: **a \$20 Copayment per visit**
- Most outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or provided in any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **a \$175 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a \$20 Copayment per procedure**

- Outpatient imaging: **no charge**
- Outpatient laboratory: **no charge**
- Outpatient diagnostic Services: **no charge**
- Outpatient administered drugs: **no charge**
- Hospital inpatient care (including room and board, imaging, laboratory, and other diagnostic and treatment Services, and Plan Physician Services): **a \$500 Copayment per admission**
- Note:
 - Administered drugs and products are medications and products that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility

For the following Services related to “Fertility Services,” refer to these sections

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

Fertility Services exclusion(s)

- Services to reverse voluntary, surgically induced infertility
- Semen and eggs (and Services related to their procurement and storage)
- Assisted reproductive technology Services, such as ovum transplants, gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT)

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 *EOC*.

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

For more information about our health education counseling, programs, and materials, please contact a

Health Education Department or our Member Service Contact Center or go to our website at **kp.org**.

Note: Our Health Education Department offers a comprehensive self-management workshop to help members learn the best choices in exercise, diet, monitoring, and medications to manage and control diabetes. Members may also choose to receive diabetes self-management training from a program outside our Plan that is recognized by the American Diabetes Association (ADA) and approved by Medicare. Also, our Health Education Department offers education to teach kidney care and help members make informed decisions about their care.

Your Cost Share. 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**
- Other covered individual counseling when the office visit is solely for health education: **a \$20 Copayment per visit**
- Health education provided during an outpatient consultation or evaluation covered in another part of this *EOC*: **no additional Cost Share beyond the Cost Share required in that other part of this *EOC***
- Covered health education materials: **no charge**

Hearing Services

We cover the following:

- Hearing exams with an audiologist to determine the need for hearing correction: **a \$20 Copayment per visit**
- Physician Specialist Visits to diagnose and treat hearing problems: **a \$20 Copayment per visit**

For the following Services related to “Hearing Services,” refer to these sections

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

Hearing Services exclusion(s)

- 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 part-time or intermittent home health care in accord with Medicare guidelines. Home health care services are covered up to the number of visits and length of time that are determined to be medically necessary under the Member’s home health treatment plan and no more than the limits established under Medicare guidelines, only if all of the following are true:

- You are substantially confined to your home
- Your condition requires the Services of a nurse, physical therapist, or speech therapist or continued need for an occupational 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
- **Your Cost Share.** We cover home health care Services at **no charge**.

For the following Services related to “Home Health Care,” refer to these sections

- Dialysis care (refer to “Dialysis Care”)
- Durable medical equipment (refer to “Durable Medical Equipment (“DME”) for Home Use”)
- Ostomy, urological, and wound care supplies (refer to “Ostomy, Urological, and Wound Care Supplies”)
- Outpatient drugs, supplies, and supplements (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)
- Outpatient physical, occupational, and speech therapy visits (refer to “Outpatient Care”)
- Prosthetic and orthotic devices (refer to “Prosthetic and Orthotic Devices”)

Home health care exclusion(s)

- 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.

If you have Medicare Part A, you may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. Your hospice doctor can be a Plan Provider or a Non-Plan Provider. Covered Services include:

- Drugs for symptom control and pain relief
- Short-term respite care
- Home care

For hospice services and services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our Plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.

For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:

If you need nonemergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal condition, your cost for these services depends on whether you use a Plan Provider:

- If you obtain the covered services from a Plan Provider, you only pay the Plan Cost Share amount
- If you obtain the covered services from a Non-Plan Provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare)

- **For services that are covered by our Plan but are not covered by Medicare Part A or B:** We will continue to cover Plan-covered Services that are not covered under Part A or B whether or not they are related to your terminal condition. You pay your Plan Cost Share amount for these Services.

- **For drugs that may be covered by our plan's Part D benefit:** Drugs are never covered by both hospice and our plan at the same time. For more information, please see "What if you're in a Medicare-certified hospice" in the "Outpatient Prescription Drugs, Supplies, and Supplements" section.

Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.

For more information about Original Medicare hospice coverage, visit <https://www.medicare.gov>, and under "Search Tools," choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or call **1-800-MEDICARE (1-800-633-4227)** (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week.

Special note if you do not have Medicare Part A

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

- You are not entitled to Medicare Part A
- 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 if you live outside our Service Area, and you have been a Senior Advantage Member continuously since before January 1, 1999, at the same home address)
- The Services are provided by a licensed hospice agency that is a Plan Provider
- A Plan Physician determines that 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, if necessary for your hospice care:

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of

emotional support to you and your family, and instruction to caregivers

- Physical, occupational, and 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 a Plan Pharmacy. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call our Member Service Contact 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
- We also cover the following hospice Services only during periods of crisis when they are Medically Necessary 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

Meals

Following discharge from a hospital due to congestive heart failure, we cover up to two meals per day in a consecutive four-week period, once per calendar year as follows:

- As part of the discharge process, someone from your care team will initiate a referral valid for 30 days. Once the referral is approved, the meal delivery vendor will contact you with meal options and arrange meal delivery. You can contact our Member Service Contact Center if you have any questions about your referral
- In addition to meals for general health, there are menus to support specific conditions and diets

Your Cost Share. We cover home-delivered meals at **no charge.**

Meals exclusion

- You are discharged to another facility that provides meals (for example, inpatient rehabilitation)

Mental Health Services

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

“Mental Disorders” include the following conditions:

- Severe Mental Illness of a person of any age
- Serious Emotional Disturbance of a Child Under Age 18
 - In addition to the Services described in this Mental Health Services section, we also cover other Services that are Medically Necessary to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness, if the Medical Group authorizes a written referral (as described in “Medical Group authorization procedure for certain referrals” under “Getting a Referral” in the “How to Obtain Services” section).

Outpatient mental health Services

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

- Individual and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

Intensive psychiatric treatment programs. We cover the following intensive psychiatric treatment programs at a Plan Facility:

- Partial hospitalization
- Multidisciplinary treatment in an intensive outpatient program
- Psychiatric observation for an acute psychiatric crisis

Your Cost Share. You pay the following for these covered Services:

- Individual mental health evaluation and treatment: **a \$20 Copayment per visit**
- Group mental health treatment: **a \$10 Copayment per visit**
- Partial hospitalization: **no charge**
- Other intensive psychiatric treatment programs: **no charge**

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized mental health treatment, the Services are generally and customarily provided by a mental health residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group mental health evaluation and treatment
- Medical services
- Medication monitoring
- Room and board
- Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, please refer to “Outpatient Prescription Drugs, Supplies, and Supplements” in this “Benefits and Your Cost Share” section)
- Discharge planning
- **Your Cost Share.** We cover residential mental health treatment Services at **no charge**.

Inpatient psychiatric hospitalization

We cover care for acute psychiatric conditions in a Medicare-certified psychiatric hospital.

Your Cost Share. We cover inpatient psychiatric hospital Services at a **\$500 Copayment per admission**.

For the following Services related to “Mental Health Services,” refer to these sections

- Outpatient drugs, supplies, and supplements (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)
- Outpatient laboratory (refer to “Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services”)
- Telehealth Visits (refer to “Telehealth Visits”)

Opioid Treatment Program Services

Opioid use disorder treatment Services are covered under Part B of Original Medicare. Members of our plan receive coverage for these Services through our plan.

Your Cost Share: You pay the following for these covered Services:

- FDA-approved opioid agonist and antagonist clinically-administered Medicare Part B drugs when provided by an Opioid Treatment Program: **no charge**
- Substance use counseling: **no charge**
- Individual and group therapy: **no charge**
- Toxicology testing: **no charge**

Ostomy, Urological, and Wound Care Supplies

We cover ostomy, urological, and wound care supplies if the following requirements are met:

- A Plan Physician has prescribed ostomy, urological, and wound care supplies for your medical condition
- The item has been approved for you through the Plan’s prior authorization process, as described in “Medical Group authorization procedure for certain referrals” under “Getting a Referral” in the “How to Obtain Services” section
- The Services are provided inside our Service Area
- Coverage is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor.

- **Your Cost Share:** You pay the following for covered ostomy, urological, and wound care supplies:
20 percent Coinsurance.

Ostomy, urological, and wound care supplies exclusion(s)

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services

We cover the following Services at the Cost Share indicated only when part of care covered under other headings in this “Benefits and Your Cost Share” section. The Services must be prescribed by a Plan Provider:

- Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans: **no charge**
- Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds: **no charge**
- Nuclear medicine: **no charge**
- Routine preventive retinal photography screenings: **no charge**
- Routine laboratory tests to monitor the effectiveness of dialysis: **no charge**
- Hemoglobin (A1c) testing for diabetes, Low-Density Lipoprotein (LDL) testing for heart disease, International Normalized Ratio (INR) for persons with liver disease or certain blood disorders, and glucose quantitative blood tests not covered at \$0 under Original Medicare: **no charge**
- All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available): **no charge**
- Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs): **no charge**
- Radiation therapy: **no charge**
- Ultraviolet light treatments: **no charge**

For the following Services related to “Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services,” refer to these sections

- Outpatient imaging and laboratory Services that are Preventive Services, such as routine mammograms, bone density scans, and laboratory screening tests (refer to “Preventive Services”)

- Outpatient procedures that include imaging and diagnostic Services (refer to “Outpatient surgeries and procedures”)
- Services related to diagnosis and treatment of infertility, artificial insemination, or assisted reproductive technology (“ART”) Services (refer to “Fertility Services”)

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this “Outpatient Prescription Drugs, Supplies, and Supplements” section when prescribed as follows:

- Items prescribed by providers, within the scope of their licensure and practice, and in accord with our drug formulary guidelines
- Items prescribed by the following Non-Plan Providers unless a Plan Physician determines that the item is not Medically Necessary or the drug is for a sexual dysfunction disorder:
 - ◆ dentists if the drug is for dental care
 - ◆ Non-Plan Physicians if the Medical Group authorizes a written referral to the Non-Plan Physician (in accord with “Medical Group authorization procedure for certain referrals” under “Getting a Referral” in the “How to Obtain Services” section) and the drug, supply, or supplement is covered as part of that referral
 - ◆ Non-Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the “Emergency Services and Urgent Care” section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described in the “Requests for Payment” section)
- The item meets the requirements of our applicable drug formulary guidelines (our Medicare Part D formulary or our formulary applicable to non-Part D items)
- You obtain the item at a Plan Pharmacy or through our mail-order service, except as otherwise described under “Certain items from Non-Plan Pharmacies” in this “Outpatient Prescription Drugs, Supplies, and Supplements” section. Please refer to our *Kaiser Permanente Pharmacy Directory* for the locations of Plan Pharmacies in your area. Plan Pharmacies can change without notice and if a pharmacy is no longer a Plan Pharmacy, you must obtain covered items from another Plan Pharmacy, except as otherwise described

under “Certain items from Non–Plan Pharmacies” in this “Outpatient Prescription Drugs, Supplies, and Supplements” section

- Your prescriber must either accept Medicare or file documentation with the Centers for Medicare & Medicaid Services showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed

In addition to our plan’s Part D and medical benefits coverage, if you have Medicare Part A, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please see “What if you’re in a Medicare-certified hospice” in this “Outpatient Prescription Drugs, Supplies, and Supplements” section.

Obtaining refills by mail

Most refills are available through our mail-order service, but there are some restrictions. A Plan Pharmacy, our *Kaiser Permanente Pharmacy Directory*, or our website at kp.org/refill can give you more information about obtaining refills through our mail-order service. Please check with your local Plan Pharmacy if you have a question about whether your prescription can be mailed. Items available through our mail-order service are subject to change at any time without notice.

Certain items from Non–Plan Pharmacies

Generally, we cover drugs filled at a Non–Plan Pharmacy only when you are not able to use a Plan Pharmacy. If you cannot use a Plan Pharmacy, here are the circumstances when we would cover prescriptions filled at a Non–Plan Pharmacy.

- The drug is related to covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the “Emergency Services and Urgent Care” section. Note: Prescription drugs prescribed and provided outside of the United States and its territories as part of covered Emergency Services or Urgent Care are covered up to a 30-day supply in a 30-day period. These drugs are covered under your medical benefits, and are not covered under Medicare Part D. Therefore, payments for these drugs do not count toward reaching the Part D Catastrophic Coverage Stage
- For Medicare Part D covered drugs, the following are additional situations when a Part D drug may be covered:
 - ◆ if you are traveling outside our Service Area, but in the United States and its territories, and you

become ill or run out of your covered Part D prescription drugs. We will cover prescriptions that are filled at a Non–Plan Pharmacy according to our Medicare Part D formulary guidelines

- ◆ if you are unable to obtain a covered drug in a timely manner inside our Service Area because there is no Plan Pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a Plan Pharmacy during normal business hours
- ◆ if you are trying to fill a prescription for a drug that is not regularly stocked at an accessible Plan Pharmacy or available through our mail-order pharmacy (including high-cost drugs)
- ◆ if you are not able to get your prescriptions from a Plan Pharmacy during a disaster

In these situations, please check first with our Member Service Contact Center to see if there is a Plan Pharmacy nearby. You may be required to pay the difference between what you pay for the drug at the Non–Plan Pharmacy and the cost that we would cover at Plan Pharmacy.

Payment and reimbursement. If you go to a Non–Plan Pharmacy for the reasons listed, you may have to pay the full cost (rather than paying just your Copayment or Coinsurance) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a request for reimbursement as described in the “Requests for Payment” section. If we pay for the drugs you obtained from a Non–Plan Pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to a Plan Pharmacy because you may be responsible for paying the difference between Plan Pharmacy Charges and the price that the Non–Plan Pharmacy charged you.

What if you’re in a Medicare-certified hospice

If you have Medicare Part A, drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication, or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. For more information about Medicare Part D coverage and what you pay, please see “Medicare Part D drugs” in this “Outpatient Prescription Drugs, Supplies, and Supplements” section.

Medicare Part D drugs

Medicare Part D covers most outpatient prescription drugs if they are sold in the United States and approved for sale by the federal Food and Drug Administration. Our Part D formulary includes drugs that can be covered under Medicare Part D according to Medicare requirements. Please refer to our “Medicare Part D drug formulary (2021 Comprehensive Formulary)” in this “Outpatient Prescription Drugs, Supplies, and Supplements” section for more information about this formulary.

Cost Share for Medicare Part D drugs. Unless you reach the Catastrophic Coverage Stage in a calendar year, you will pay the following Cost Share for covered Medicare Part D drugs:

- Generic drugs: **a \$10 Copayment for up to a 100-day supply**
- Brand-name and specialty drugs: **a \$35 Copayment for up to a 100-day supply**
- Injectable Part D vaccines: **no charge**
- Emergency contraceptive pills: **no charge**
- The following insulin-administration devices at a **\$10 Copayment** for up to a 100-day supply: needles, syringes, alcohol swabs, and gauze

Catastrophic Coverage Stage. All Medicare prescription drug plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend **\$6,550** out-of-pocket during 2021. When the total amount you have paid for your Cost Share reaches **\$6,550**, you will pay the following for the remainder of 2021:

- **a \$3 Copayment** per prescription for insulin administration devices and generic drugs
- **a \$10 Copayment** per prescription for brand-name and specialty drugs
- Injectable Part D vaccines: **no charge**
- Emergency contraceptive pills: **no charge**

Note: Each year, effective on January 1, the Centers for Medicare & Medicaid Services may change coverage thresholds and catastrophic coverage Copayments that

apply for the calendar year. We will notify you in advance of any change to your coverage.

These payments are included in your out-of-pocket costs. When you add up your out-of-pocket costs, you can include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in this “Outpatient Prescription Drugs, Supplies, and Supplements” section):

- The amount you pay for drugs when you are in the Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our Plan

It matters who pays:

- If you make these payments yourself, they are included in your out-of-pocket costs
- These payments are also included if they are made on your behalf by certain other individuals or organizations. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare’s Extra Help Program are also included

These payments are not included in your out-of-pocket costs. When you add up your out-of-pocket costs, you are not allowed to include any of these types of payments for prescription drugs:

- The amount you contribute, if any, toward your group’s Premium
- Drugs you buy outside the United States and its territories
- Drugs that are not covered by our Plan
- Drugs you get at an out-of-network pharmacy that do not meet our Plan’s requirements for out-of-network coverage
- Prescription drugs covered by Part A or Part B
- Payments you make toward prescription drugs not normally covered in a Medicare prescription drug plan
- Payments for your drugs that are made or funded by group health plans, including employer health plans
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and Veterans Affairs
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers’ Compensation)

Reminder: If any other organization such as the ones described above pays part or all of your out-of-pocket costs for Part D drugs, you are required to tell our Plan. Call our Member Service Contact Center to let us know (phone numbers are on the cover of this *EOC*).

Keeping track of Medicare Part D drugs. The *Part D Explanation of Benefits* is a document you will get for each month you use your Part D prescription drug coverage. The *Part D Explanation of Benefits* will tell you the total amount you, or others on your behalf, have spent on your prescription drugs and the total amount we have paid for your prescription drugs. A *Part D Explanation of Benefits* is also available upon request from our Member Service Contact Center.

Medicare’s “Extra Help” Program

Medicare provides “Extra Help” to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan’s monthly premium, and prescription Copayments. This “Extra Help” also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for “Extra Help.” Some people automatically qualify for “Extra Help” and don’t need to apply. Medicare mails a letter to people who automatically qualify for “Extra Help.”

You may be able to get “Extra Help” to pay for your prescription drug premiums and costs. To see if you qualify for getting “Extra Help,” call:

- **1-800-MEDICARE (1-800-633-4227)** (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week;
- The Social Security Office at **1-800-772-1213** (TTY users call **1-800-325-0778**), 7 a.m. to 7 p.m., Monday through Friday (applications); or
- Your state Medicaid office (applications). See the “Important Phone Numbers and Resources” section for contact information

If you believe you have qualified for “Extra Help” and you believe that you are paying an incorrect Cost Share amount when you get your prescription at a Plan Pharmacy, our plan has established a process that allows you either to request assistance in obtaining evidence of your proper Cost Share level, or, if you already have the evidence, to provide this evidence to us. If you aren’t sure what evidence to provide us, please contact a Plan Pharmacy or our Member Service Contact Center. The evidence is often a letter from either your state Medicaid

or Social Security office that confirms you are qualified for Extra Help. The evidence may also be state-issued documentation with your eligibility information associated with Home and Community-Based Services.

You or your appointed representative may need to provide the evidence to a Plan Pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate Cost Share amount until the Centers for Medicare & Medicaid Services updates its records to reflect your current status. Once the Centers for Medicare & Medicaid Services updates its records, you will no longer need to present the evidence to the Plan Pharmacy. Please provide your evidence in one of the following ways so we can forward it to the Centers for Medicare & Medicaid Services for updating:

- Write to Kaiser Permanente at:
California Service Center
Attn: Best Available Evidence
P.O. Box 232407
San Diego, CA 92193-2407
- Fax it to **1-877-528-8579**
- Take it to a Plan Pharmacy or your local Member Services office at a Plan Facility

When we receive the evidence showing your Cost Share level, we will update our system so that you can pay the correct Cost Share when you get your next prescription at our Plan Pharmacy. If you overpay your Cost Share, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future Cost Share. If our Plan Pharmacy hasn’t collected a Cost Share from you and is carrying your Cost Share as a debt owed by you, we may make the payment directly to our Plan Pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please call our Member Service Contact Center if you have questions.

If you qualify for “Extra Help,” we will send you an *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low Income Subsidy Rider* or the *LIS Rider*), that explains your costs as a Member of our plan. If the amount of your “Extra Help” changes during the year, we will also mail you an updated *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*.

Medicare Part D drug formulary (2021 Comprehensive Formulary)

Our Medicare Part D formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers that represents the drug therapies believed to be a necessary part of a quality treatment program.

Our formulary must meet requirements set by Medicare and is approved by Medicare. Our formulary includes drugs that can be covered under Medicare Part D according to Medicare requirements. For a complete, current listing of the Medicare Part D prescription drugs we cover, please visit our website at kp.org/seniorrx or call our Member Service Contact Center.

The presence of a drug on our formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition. Our drug formulary guidelines allow you to obtain Medicare Part D prescription drugs if a Plan Physician determines that they are Medically Necessary for your condition. If you disagree with your Plan Physician's determination, refer to "Your Part D Prescription Drugs: How to Ask for a Coverage Decision or Make an Appeal" in the "Coverage Decisions, Appeals, and Complaints" section.

Continuity drugs. If this *EOC* is amended to exclude a drug that we have been covering and providing to you under this *EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the Federal Food and Drug Administration.

About specialty drugs. Specialty drugs are high-cost drugs that are on our specialty drug list. If your Plan Physician prescribes more than a 30-day supply for an outpatient drug, you may be able to obtain more than a 30-day supply at one time, up to the day supply limit for that drug. However, most specialty drugs are limited to a 30-day supply in any 30-day period. Your Plan Pharmacy can tell you if a drug you take is one of these drugs.

Preferred generic and generic drugs listed in the formulary will be subject to the generic drug Copayment or Coinsurance listed under "Copayment and Coinsurance for Medicare Part D drugs" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. Preferred and nonpreferred brand-name drugs and specialty tier drugs listed in the formulary will be subject to the brand-name Copayment or Coinsurance listed under "Copayment and Coinsurance for Medicare Part D drugs" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. Please note that sometimes a drug may appear more than once on our *2021 Comprehensive Formulary*. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

You can get updated information about the drugs our plan covers by visiting our website at kp.org/seniorrx. You may also call our Member Service Contact Center to find out if your drug is on the formulary or to request an updated copy of our formulary.

We may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary
- Adding prior authorizations or other restrictions on a drug

If we remove drugs from the formulary or add prior authorizations or restrictions on a drug, and you are taking the drug affected by the change, you will be permitted to continue receiving that drug at the same level of Cost Share for the remainder of the calendar year. However, if a brand-name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 30 days before the date that the change becomes effective or provide you with at least a month's supply at the Plan Pharmacy. This will give you an opportunity to work with your physician to switch to a different drug that we cover or request an exception. (If a drug is removed from our formulary because the drug has been recalled, we will not give 30 days' notice before removing the drug from the formulary. Instead, we will remove the drug immediately and notify members taking the drug about the change as soon as possible.)

If your drug isn't listed on your copy of our formulary, you should first check the formulary on our website, which we update when there is a change. In addition, you may call our Member Service Contact Center to be sure it isn't covered. If Member Services confirms that we don't cover your drug, you have two options:

- You may ask your Plan Physician if you can switch to another drug that is covered by us
- You or your Plan Physician may ask us to make an exception (a type of coverage determination) to cover your Medicare Part D drug. See the "Coverage Decisions, Complaints, and Appeals" section for more information on how to request an exception

Transition policy. If you recently joined our plan, you may be able to get a temporary supply of a Medicare Part D drug you were previously taking that may not be on our formulary or has other restrictions, during the first 90 days of your membership. Current members may also

be affected by changes in our formulary from one year to the next. Members should talk to their Plan Physicians to decide if they should switch to a different drug that we cover or request a Part D formulary exception in order to get coverage for the drug. Please refer to our formulary or our website, kp.org/seniorrx, for more information about our Part D transition coverage.

Medicare Part D exclusions (non-Part D drugs). By law, certain types of drugs are not covered by Medicare Part D. If a drug is not covered by Medicare Part D, any amounts you pay for that drug will not count toward reaching the Catastrophic Coverage Stage. A Medicare Prescription Drug Plan can't cover a drug under Medicare Part D in the following situations:

- The drug would be covered under Medicare Part A or Part B
- Drug purchased outside the United States and its territories
- Off-label uses (meaning for uses other than those indicated on a drug's label as approved by the federal Food and Drug Administration) of a prescription drug, except in cases where the use is supported by certain reference books. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.) If the use is not supported by one of these references, known as compendia, then the drug is considered a non-Part D drug and cannot be covered under Medicare Part D coverage

In addition, by law, certain types of drugs or categories of drugs are not covered under Medicare Part D. These drugs include:

- Nonprescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be

purchased exclusively from the manufacturer as a condition of sale

Note: In addition to the coverage provided under this Medicare Part D plan, you also have coverage for non-Part D drugs described under "Home infusion therapy," "Outpatient drugs covered by Medicare Part B," "Certain intravenous drugs, supplies, and supplements," and "Outpatient drugs, supplies, and supplements not covered by Medicare" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. If a drug is not covered under Medicare Part D, please refer to those headings for information about your non-Part D drug coverage.

Other prescription drug coverage. If you have additional health care or drug coverage from another plan, you must provide that information to our plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional health care or prescription drug coverage, please call our Member Service Contact Center to update your membership records.

Home infusion therapy

We cover home infusion supplies and drugs at **no charge** if all of the following are true:

- Your prescription drug is on our Medicare Part D formulary
- We approved your prescription drug for home infusion therapy
- Your prescription is written by a network provider and filled at a network home-infusion pharmacy

Outpatient drugs covered by Medicare Part B

In addition to Medicare Part D drugs, we also cover the limited number of outpatient prescription drugs that are covered by Medicare Part B. The following are the types of drugs that Medicare Part B covers:

- Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services
- Drugs you take using durable medical equipment (such as nebulizers) that were prescribed by a Plan Physician
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive drugs, if Medicare paid for the transplant (or a group plan was required to pay before Medicare paid for it)

- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anticancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when Medically Necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

Your Cost Share for Medicare Part B drugs. You pay the following for Medicare Part B drugs:

- Generic drugs: **a \$10 Copayment for up to a 100-day supply**
- Brand-name drugs, specialty drugs, and compounded products: **a \$35 Copayment for up to a 100-day supply**

Certain intravenous drugs, supplies, and supplements

We cover certain self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an intravenous or intraspinal-infusion) at **no charge** for up to a 30-day supply. In addition, we cover the supplies and equipment required for the administration of these drugs at **no charge**.

Outpatient drugs, supplies, and supplements not covered by Medicare

If a drug, supply, or supplement is not covered by Medicare Part B or D, we cover the following additional items in accord with our non-Part D drug formulary:

- Drugs for which a prescription is required by law that are not covered by Medicare Part B or D. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary applicable to non-Part D items
- Diaphragms, cervical caps, contraceptive rings, and contraceptive patches
- Disposable needles and syringes needed for injecting covered drugs, pen delivery devices, and visual aids required to ensure proper dosage (except eyewear), that are not covered by Medicare Part B or D
- Inhaler spacers needed to inhale covered drugs

- Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing
- FDA-approved medications for tobacco cessation, including over-the-counter medications when prescribed by a Plan Physician

Your Cost Share for other outpatient drugs, supplies, and supplements. Your Cost Share for these items is as follows:

- Generic items (that are not described elsewhere in this *EOC*): **a \$10 Copayment for up to a 100-day supply**
- Brand-name items, specialty drugs, and compounded products (that are not described elsewhere in this *EOC*): **a \$35 Copayment for up to a 100-day supply**
- Drugs prescribed for the treatment of sexual dysfunction disorders: **25 percent Coinsurance for up to a 100-day supply**
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge** for up to a 30-day supply
- Diabetes urine-testing supplies: **no charge** for up to a 100-day supply
- Tobacco cessation drugs: **no charge**. For over-the-counter medications, we cover up to two 100-day supplies per calendar year

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

Non-Part D drug formulary. The non-Part D drug formulary includes a list of drugs that our Pharmacy and Therapeutics Committee has approved for our Members. Our Pharmacy and Therapeutics Committee, which is primarily composed of Plan Physicians, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature. The Pharmacy and Therapeutics Committee meets at least quarterly to consider additions and deletions based on new information or drugs that become available. To find out which drugs are on the formulary for your plan, please visit our website at kp.org/formulary. If you would like to request a copy of the non-Part D drug formulary for your plan, please call our Member Service Contact Center. Note: The presence of a drug on the drug formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition.

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

About specialty drugs. Specialty drugs are high-cost drugs that are on our specialty drug list. If your Plan Physician prescribes more than a 30-day supply for an outpatient drug, you may be able to obtain more than a 30-day supply at one time, up to the day supply limit for that drug. However, most specialty drugs are limited to a 30-day supply in any 30-day period. Your Plan Pharmacy can tell you if a drug you take is one of these drugs.

Drug utilization review

We conduct drug utilization reviews to make sure that you are getting safe and appropriate care. These reviews are especially important if you have more than one doctor who prescribes your medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors
- Unsafe amounts of opioid pain medications

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Drug management program

We have a program that can help make sure our members safely use their prescription opioid medications, or other medications that are frequently abused. This program is called a Drug Management

Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide you are at risk for misusing or abusing your opioid or benzodiazepine medications, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one pharmacy.
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one doctor.
- Limiting the amount of opioid or benzodiazepine medications we will cover for you.

If we decide that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the terms of the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug abuse or the limitation, you and your prescriber have the right to ask us for an appeal. See the "Coverage Decisions, Appeals, and Complaints" section for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer, you are receiving hospice, palliative, or end-of-life care, or you live in a long-term care facility.

Medication therapy management program

We offer a medication therapy management program at no additional cost to Members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. This program was developed for us by a team of pharmacists and doctors. We use this medication therapy management program to help us provide better care for our members. For example, this program helps us make sure that you are using appropriate drugs to treat your medical conditions and help us identify possible medication errors.

If you are selected to join a medication therapy management program, we will send you information about the specific program, including information about how to access the program.

ID card at Plan Pharmacies

You must present your Kaiser Permanente ID card when obtaining covered items from Plan Pharmacies, including those that are not owned and operated by Kaiser Permanente. If you do not have your ID card, the Plan

Pharmacy may require you to pay Charges for your covered items, and you will have to file a claim for reimbursement as described in the “Requests for Payment” section.

Notes:

- If Charges for a covered item are less than the Copayment, you will pay the lesser amount
- Durable medical equipment used to administer drugs, such as diabetes insulin pumps (and their supplies) and diabetes blood-testing equipment (and their supplies) are not covered under this “Outpatient Prescription Drugs, Supplies, and Supplements” section (instead, refer to “Durable Medical Equipment (“DME”) for Home Use” in this “Benefits and Your Cost Share” section)
- Except for vaccines covered by Medicare Part D, drugs administered to you in a Plan Medical Office or during home visits are not covered under this “Outpatient Prescription Drugs, Supplies, and Supplements” section (instead, refer to “Outpatient Care” in this “Benefits and Your Cost Share” section)
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility are not covered under this “Outpatient Prescription Drugs, Supplies, and Supplements” section (instead, refer to “Hospital Inpatient Care” and “Skilled Nursing Facility Care” in this “Benefits and Your Cost Share” section)

Outpatient prescription drugs, supplies, and supplements limitations

Day supply limit. Plan Physicians determine the amount of a drug or other item that is Medically Necessary for a particular day supply for you. Upon payment of the Cost Share specified in this “Outpatient Prescription Drugs, Supplies, and Supplements” section, you will receive the supply prescribed up to a 100-day supply in a 100-day period. However, the Plan Pharmacy may reduce the day supply dispensed to a 30-day supply in any 30-day period at the Cost Share listed in this “Outpatient Prescription Drugs, Supplies, and Supplements” section if the Plan Pharmacy determines that the drug is in limited supply in the market or a 31-day supply in any 31-day period if the item is dispensed by a long term care facility’s pharmacy. Plan Pharmacies may also limit the quantity dispensed as described under “Utilization management.” If you wish to receive more than the covered day supply limit, then the additional amount is not covered and you must pay Charges for any prescribed quantities that exceed the day supply limit. The amount you pay for noncovered drugs does not count toward reaching the Catastrophic Coverage Stage.

Utilization management. For certain items, we have additional coverage requirements and limits that help promote effective drug use and help us control drug plan costs. Examples of these utilization management tools are:

- **Quantity limits:** The Plan Pharmacy may reduce the day supply dispensed at the Cost Share specified in this “Outpatient Drugs, Supplies, and Supplements” section to a 30-day supply or less in any 30-day period for specific drugs. Your Plan Pharmacy can tell you if a drug you take is one of these drugs. In addition, we cover episodic drugs prescribed for the treatment of sexual dysfunction up to a maximum of eight doses in any 30-day period, up to 16 doses in any 60-day period, or up to 27 doses in any 100-day period. Also, when there is a shortage of a drug in the marketplace and the amount of available supplies, we may reduce the quantity of the drug dispensed accordingly and charge one cost share
- **Generic substitution:** When there is a generic version of a brand-name drug available, Plan Pharmacies will automatically give you the generic version, unless your Plan Physician has specifically requested a formulary exception because it is Medically Necessary for you to receive the brand-name drug instead of the formulary alternative

Outpatient prescription drugs, supplies, and supplements exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy’s standard packaging
- Compounded products unless the active ingredient in the compounded product is listed on one of our drug formularies
- Drugs prescribed to shorten the duration of the common cold
- Prescription drugs for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug). This exclusion does not apply to:
 - ◆ insulin
 - ◆ over-the-counter tobacco cessation drugs and contraceptive drugs
 - ◆ an entire class of prescription drugs when one drug within that class becomes available over-the-counter
 - ◆ drugs covered by Medicare Parts B or D

Preventive Services

We cover a variety of Preventive Services in accord with Medicare guidelines. The list of Preventive Services is subject to change by the Centers for Medicare & Medicaid Services. These Preventive Services are subject to all coverage requirements described in this “Benefits and Your Cost Share” section and all provisions in the “Exclusions, Limitations, Coordination of Benefits, and Reductions” section. If you have questions about Preventive Services, please call our Member Service Contact Center.

Note: If you receive any other covered Services that are not Preventive Services during or subsequent to a visit that includes Preventive Services on the list, you will pay the applicable Cost Share for those other Services. For example, if laboratory tests or imaging Services ordered during a preventive office visit are not Preventive Services, you will pay the applicable Cost Share for those Services.

Your Cost Share. You pay the following for covered Preventive Services:

- Abdominal aortic aneurysm screening prescribed during the one-time “Welcome to Medicare” preventive visit: **no charge**
- Annual Wellness visit: **no charge**
- Bone mass measurement: **no charge**
- Breast cancer screening (mammograms): **no charge**
- Cardiovascular disease risk reduction visit (therapy for cardiovascular disease): **no charge**
- Cardiovascular disease testing: **no charge**
- Cervical and vaginal cancer screening: **no charge**
- Colorectal cancer screening, including flexible sigmoidoscopies, colonoscopies, and fecal occult blood tests: **no charge**
- Depression screening: **no charge**
- Diabetes screening, including fasting glucose tests: **no charge**
- Diabetes self-management training: **no charge**
- Glaucoma screening: **no charge**
- HIV screening: **no charge**
- Immunizations (including the vaccine) covered by Medicare Part B such as Hepatitis B, influenza, and pneumococcal vaccines that are administered to you in a Plan Medical Office: **no charge**
- Lung cancer screening: **no charge**
- Medical nutrition therapy for kidney disease and diabetes: **no charge**
- Medicare diabetes prevention program: **no charge**
- Obesity screening and therapy to promote sustained weight loss: **no charge**
- Prostate cancer screening exams, including digital rectal exams and Prostate Specific Antigens (PSA) tests: **no charge**
- Screening and counseling to reduce alcohol misuse: **no charge**
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs: **no charge**
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use): **no charge**
- “Welcome to Medicare” preventive visit: **no charge**

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices coverage rules

We cover the prosthetic and orthotic devices specified in this “Prosthetic and Orthotic Devices” section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select
- The item has been approved for you through the Plan’s prior authorization process, as described in “Medical Group authorization procedure for certain referrals” under “Getting a Referral” in the “How to Obtain Services” section
- The Services are provided inside our Service Area

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

Base prosthetic and orthotic devices

If all of the requirements described under “Prosthetic and orthotic coverage rules” in this “Prosthetics and Orthotic Devices” section are met, we cover the items described in this “Base prosthetic and orthotic devices” section.

Internally implanted devices. We cover prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, in accord with Medicare guidelines, if they are