



## **KAISER PERMANENTE**

Kaiser Foundation Health Plan, Inc.  
Electronic Documents Policy

This policy document constitutes the explicit, written permission of Kaiser Foundation Health Plan, Inc., (Health Plan) for the Purchaser to use the accompanying Health Plan Enrollment and Member electronic documents under the following conditions:

These electronic documents must be used as provided, without additions, deletions, or other modifications.

These electronic documents are being provided in English. Translation of these documents by any person/organization other than by Health Plan (or certified translation agencies authorized by Health Plan) is prohibited. Please contact your Health Plan account representative to learn which documents are available in other languages.

These electronic documents may be posted to Purchaser Web sites.

Health Plan will provide updated versions of these electronic documents if there are substantive language changes. Purchasers must transfer the updated versions to their sites as soon as reasonably possible, but not later than 30 days after receipt of an updated document.

The Disclosure Form (DF) is subject to change. Health Plan will provide substantive DF language changes electronically to Purchasers. It is the Purchaser's responsibility to ensure that all changes are provided to employees. All electronic DF documents include a footnote containing an original issuance date to ensure accurate tracking.

If you have questions about our Electronic Documents Policy, or questions about a specific request for an electronic document, please contact your account representative for assistance.

Kaiser Foundation Health Plan, Inc.  
California Division



**KAISER PERMANENTE®**

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

*A nonprofit corporation*

**Kaiser Permanente Traditional Plan  
Evidence of Coverage for  
D & D TOOL AND SUPPLY**

Purchaser ID: 119695 Contract: 1 Version: 14 EOC Number: 1

***January 1, 2004 through December 31, 2004***

Member Service Call Center  
7 a.m. to 7 p.m.  
Seven days a week (except holidays)  
**1-800-464-4000**  
*Hearing and speech impaired*  
*TTY line 1-800-777-1370*  
[www.kaiserpermanente.org](http://www.kaiserpermanente.org)

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## **Introduction**

This *Evidence of Coverage (EOC)* describes the health care coverage of "Kaiser Permanente Traditional Plan" provided under the *Agreement* between Kaiser Foundation Health Plan, Inc., and your Group. For benefits provided under any other Health Plan program, refer to that plan's *Evidence of Coverage*. In this *EOC*, Kaiser Foundation Health Plan, Inc., is sometimes referred to as "Health Plan," "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.

**Please read the following information so that you will know from whom or what group of providers you may get health care.** It is important to familiarize yourself with your coverage by reading this *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.

### **Term of this EOC**

This *EOC* is for the period January 1, 2004 through December 31, 2004 unless amended. Your Group's benefits administrator can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended.

### **About Kaiser Permanente**

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Our Health Plan, Plan Hospitals, and 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, and other benefits described in the "Benefits" section.

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 following sections about:

- Getting a referral, in the "How to Obtain Services" section
- Our Visiting Member Program, in the "How to Obtain Services" section
- Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care received from non-Plan Providers, in the "Emergency, Urgent, and Routine Care" section

## **Dues, Eligibility, and Enrollment**

### **Dues**

Your Group is responsible for paying Dues. If you are responsible for any contribution to the Dues, your Group will tell you the amount 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 in this "Who Is Eligible" section.

### **Group eligibility requirements**

You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of its eligibility requirements, such as the minimum number of hours that employees must work to be eligible for coverage. Please note that your Group might not allow enrollment to some persons who meet the requirements under "Service Area eligibility requirements" and "Additional eligibility requirements."

## Service Area eligibility requirements

The Subscriber must live or work in our Service Area at the time he or she enrolls. The "Definitions" section describes our Service Area and how it may change. You cannot enroll or continue enrollment as a Subscriber or Dependent if you live in or move to a Region outside California except as described below. If you move anywhere else outside our Service Area after enrollment, you can continue your membership as long as you meet all other eligibility requirements. However, you must receive covered Services from Plan Providers inside our Service Area, except for Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care received from non-Plan Providers described in the "Emergency, Urgent, and Routine Care" section and "Our Visiting Member Program" described in the "How to Obtain Services" section.

**Regions outside California.** If you live in or move to the service area of a Region outside California, you are not eligible for membership under this *EOC* (unless one of the exceptions listed below applies to you). Please contact your Group's benefits administrator to learn about your Group health care options. You may be able to enroll in the new service area if there is an agreement between your Group and the Region, but the coverage, dues, and eligibility requirements might not be the same in the other service area.

**Exceptions** — This restriction does not apply to the following persons (see "Our Visiting Member Program" in the "How to Obtain Services" section for information about benefits when you are in another service area):

- A Subscriber who works inside our Service Area
- The Subscriber's or the Subscriber's Spouse's children
- Members who are eligible under this *EOC* because of COBRA, Cal-COBRA, or USERRA coverage (please refer to the "Continuation of Membership" section for information about COBRA, Cal-COBRA, or USERRA coverage)

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

**Northern California Region's service area.** If you live in or are moving to our Northern California Region's service area, please contact your Group's benefits administrator to learn about your Group health care options. Your Group may have an arrangement with us that permits membership in the Northern California Region, but the coverage, dues, and eligibility requirements might not be the same as under this *EOC*.

## Additional eligibility requirements

You may be eligible to enroll 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 IRS considers you self-employed)

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

- Your Spouse. For the purposes of this *EOC*, the term "Spouse" includes your domestic partner, in accord with your Group's requirements that we approve in writing
- Your or your Spouse's unmarried children (including adopted children or children placed with you for adoption) who are under age 19, or under age 24 if a student as defined by your Group
- Other unmarried dependent persons (but not including foster children) who meet all of the following requirements:
  - ◆ they are under age 19, or under age 24 if a student as defined by your Group
  - ◆ they receive all of their support and maintenance from you or your Spouse
  - ◆ they permanently reside with you (the Subscriber)
  - ◆ you or your Spouse is the court-appointed guardian (or was before the person reached age 18) or the person's parent is an enrolled Dependent under your family coverage

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

### Persons barred from enrolling in Health Plan

- Persons who have had their entitlement to receive Services through Health Plan either rescinded or terminated for cause cannot enroll
- Persons who have had entitlement to receive Services through Health Plan terminated for failure to pay individual (nongroup) plan dues or failure to pay any amounts owed to Health Plan or a Plan Provider cannot enroll, unless we agree to allow you to enroll after you pay all amounts owed by you and your dependents

### Members with Medicare and retirees

This plan 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's benefits administrator about your membership options as follows:

- If a Subscriber retires who is entitled to Medicare Parts A and B, 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 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 of this EOC
- If federal law requires that your Group's health care plan 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 be eligible to enroll in Kaiser Permanente Senior Advantage through your Group if you are entitled to Medicare Parts A and B
- If you are or become eligible for Medicare and are in a class of beneficiaries for which your Group's health care plan is secondary to Medicare, you should enroll 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's benefits administrator about your membership options

**When Medicare is primary.** If you are or become eligible for Medicare Part A or Part B (or both), 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), your Group's Dues may increase. If your Group fails to pay the entire Dues required for your Family Unit, your membership will be terminated in accord with "Partial payment of Dues for a Family Unit" under "Termination for Nonpayment" in the "Termination of Membership" section.

**When Medicare is secondary.** Medicare is the primary coverage except when federal law requires that your Group's health care plan be primary and Medicare coverage be secondary. Members eligible for Medicare as their secondary coverage are subject to the same Dues and receive the same benefits as Members who are not eligible for Medicare. However, any such Members who meet the eligibility requirements for our Kaiser Permanente Senior Advantage plan may enroll in Senior Advantage if the plan is available to you. These Members receive the benefits and coverage described in the Kaiser Permanente Senior Advantage (MSP) EOC.

Note: You may be ineligible to enroll in Kaiser Permanente Senior Advantage if that plan has reached a capacity limit that the Centers for Medicare & Medicaid Services has approved. This limitation does not apply to existing Members who are eligible for Medicare (for example, when you turn age 65).

### When You Can Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and your effective date of coverage. If you are eligible to enroll as described under "Who Is Eligible" in this "Dues, Eligibility, and Enrollment" section, enrollment is permitted as follows and membership begins at the very beginning (12:00 a.m.) of the effective

date of coverage indicated below (your Group may have additional requirements that we have approved, which allow enrollment in other situations).

### **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 30 days.

**Effective date of coverage.** The effective date of coverage for new employees and their eligible family Dependents is the first of the month following a 90-day probationary period.

### **Newly acquired Dependents**

To enroll a Dependent who becomes eligible to enroll after you became a Subscriber (such as a new Spouse, a newborn child, or a newly adopted child), you must submit a Health Plan–approved change of enrollment form to your Group within 30 days after the Dependent becomes eligible. Also, refer to "Special enrollment due to new Dependents" below.

**Effective date of coverage.** Other than a newborn or a newly adopted child (including a child placed with you for adoption), the effective date of coverage for newly acquired Dependents is the first of the month following the date of acquisition. For a newborn or a newly adopted child, the effective date of coverage is as follows:

- A newborn child is covered from the moment of birth if the Subscriber enrolls the child within 30 days after birth. Any Dues required for the newborn will be effective the first of the month following birth
- If the newborn child is not enrolled within 30 days, the newborn is covered only through the calendar month of birth, or the mother's hospitalization if she is a Member, whichever is later
- A newly adopted child's (including a child placed with you for adoption) membership will begin on the date when the adopting parent gains the legal right to control the child's health care if the Subscriber enrolls the child within 31 days of that date

### **Special enrollment due to new Dependents**

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days of marriage, birth, adoption, or placement for adoption by submitting to your Group an enrollment or change of enrollment application in a form agreed upon by your Group and Health Plan.

**Effective date of coverage.** The effective date of an enrollment resulting from marriage is no later than the first day of the month following the date that the Subscriber signs an enrollment or change of enrollment application. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, adoption, or placement for adoption.

### **Special enrollment due to loss of other coverage**

An employee and the employee's eligible Dependents may enroll within 30 days of losing other coverage by submitting to your Group an enrollment or change of enrollment application in a form agreed upon by your Group and Health Plan. The employee who is requesting enrollment must have previously waived coverage for self or family Dependents when originally eligible because of the other coverage. In addition, the loss of the other coverage must be due to ineligibility to continue the other coverage, Group continuation of coverage has expired, or the other employer has ceased making contributions toward the other coverage and the loss of coverage is not due to nonpayment or cause. The employee must enroll or be enrolled in order to enroll a family Dependent.

**Effective date of 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 that the Subscriber signs an enrollment or change of enrollment application.

### **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 coverage for a child who meets the eligibility requirements as a Dependent, the Subscriber may add the child as a Dependent by submitting to Group an enrollment or change of enrollment application in a form agreed upon by Group and Health Plan.

**Effective date of coverage.** The effective date of an enrollment resulting from a court or administrative order is the first of the month following the date of the court order.

### **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 the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage.

### **Notice to New Enrollees about Continuity of Care**

If you are currently receiving Services from a non–Plan Provider for an acute medical condition or an acute, serious, or chronic psychiatric condition and your enrollment with us will end coverage of the provider's Services, you may be eligible for temporary coverage of that non–Plan Provider's Services while your care is being transferred to us.

To qualify for this temporary coverage, all of the following criteria must be true:

- Your Health Plan coverage is in effect
- You request this continuing coverage no later than 30 days from your effective date of coverage by calling our Member Service Call Center
- You are receiving Services during a current episode of care for an acute medical condition or an acute, serious, or chronic psychiatric condition from a non–Plan Provider on the effective date of your Health Plan coverage
- When you chose Health Plan, you were not offered other coverage that included an out-of-network option that would have covered the Services of your current non–Plan Provider
- You did not have the option to continue with your previous health plan or to choose a plan that covers the Services of your current non–Plan Provider
- The non–Plan Provider agrees in writing to our standard contractual terms and conditions, such as conditions pertaining to payment, and providing Services inside our Service Area
- The Services to be provided to you by the non–Plan Provider are Medically Necessary and would be covered Services under the terms of your Health Plan coverage, if provided by a Plan Provider
- Medical Group authorizes the care of your non–Plan Provider because Plan Providers are unable to maintain the continuity of your care

To request this coverage or a copy of our coverage policy, please call our Member Service Call Center.

## **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 following sections about:

- Getting a referral, in this section
- Our Visiting Member Program, in this section
- Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care received from non–Plan Providers, in the "Emergency, Urgent, and Routine Care" 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, and other benefits described in the "Benefits" section.

### **Your Primary Care Plan Physician**

Your primary care Plan Physician plays an important role in coordinating your medical care needs, including hospital stays and referrals to specialists. We encourage you to choose a primary care Plan Physician. You may select a primary care Plan Physician from any of our available Plan Physicians who practice in these specialties: internal medicine, obstetrics/gynecology, family practice, and pediatrics. You can also select a new primary care

Plan Physician for any reason from any of our available Plan Physicians. To learn how to select a primary care Plan Physician, please call our Member Service Call Center.

### **Special note about Coachella Valley and western Ventura County**

Subscribers residing in Coachella Valley and western Ventura County are required to select a primary care Plan Physician (Affiliated Physician) for themselves and each covered Dependent. In these areas, Plan Providers (except for Plan Pharmacies that are owned and operated by Kaiser Permanente) are referred to as "Affiliated Providers," for example "Affiliated Physicians" and "Affiliated Hospitals." Please refer to our Service Area description in the "Definitions" section for the ZIP codes that are in these two areas.

Your primary care Affiliated Physician will provide or arrange your care in these areas, including Services from other Affiliated Providers, such as specialty Affiliated Physicians. **For Services from Affiliated Providers to be covered, your primary care Affiliated Physician must prescribe the care or authorize the referral**, except for annual mammograms and visits to your obstetrics/gynecology Affiliated Physician, which you can get directly without a referral from your primary care Affiliated Physician. Also, you may receive care from Plan Providers outside of Coachella Valley and western Ventura County without a referral from your primary care Affiliated Physician (although some care requires a referral from a primary care Plan Physician, who need not be an Affiliated Physician; for more details see "Referrals to Plan Providers" in this "How to Obtain Services" section).

We will send the Subscriber a letter explaining how to select a primary care Affiliated Physician. If the Subscriber does not select a primary care Affiliated Physician, we will assign one. Dependents may select a different primary care Affiliated Physician from the Subscriber's by calling our Member Service Call Center. You may change your primary care Affiliated Physician once a month. If you need care before we have confirmed your primary care Affiliated Physician, please call our Member Service Call Center for assistance. To learn about Affiliated Providers, please refer to *Your Guidebook*.

If the Subscriber in your Family Unit does not live in Coachella Valley or western Ventura County, you may receive covered care from Affiliated Providers in these areas even if you haven't chosen a primary care Affiliated Physician.

### **Getting a Referral**

#### **Referrals to Plan Providers**

Primary care Plan Physicians provide primary medical, pediatric, and obstetrics/gynecology care. Plan specialists provide specialty care in areas such as surgery, orthopedics, cardiology, oncology, urology, and dermatology. A Plan Physician will refer you to a Plan specialist when appropriate. You don't need a referral to receive primary care from Plan Physicians in the following areas: internal medicine, obstetrics/gynecology, family planning, family practice, pediatrics, optometry, psychiatry, and chemical dependency. Please check *Your Guidebook* to see if your facility has other departments that don't require a referral. Also, please refer to "Special note about Coachella Valley and western Ventura County" in this "How to Obtain Services" section for additional requirements that apply when a Subscriber lives in these areas.

#### **Medical Group authorization procedure for certain referrals**

The following Services require prior authorization by Medical Group for the Services to be covered:

- **Services not available from Plan Providers.** If your Plan Physician decides that you require covered Services not available from Plan Providers, he or she will recommend to Medical Group that you be referred to a non-Plan Provider inside or outside our Service Area. The appropriate Medical Group designee will authorize the Services if he or she determines that they are Medically Necessary but not available from a Plan Provider
- **Bariatric surgery.** If your Plan Physician makes a written referral for bariatric surgery, Medical Group's regional Bariatric Medical Director or his or her designee will authorize the Service if he or she determines that it is Medically Necessary in accord with Medical Group's bariatric surgery referral guidelines
- **Durable medical equipment (DME).** If your Plan Physician prescribes DME, he or she will submit a written referral to the Plan Hospital's DME Coordinator, who will authorize the DME if he or she determines that your DME coverage includes the item and that the item is listed on our formulary for your condition. If the item doesn't appear to meet our DME formulary guidelines, then the DME Coordinator will contact the Plan Physician for additional information about the request. If the request still doesn't appear to meet our DME

formulary guidelines, the request will be submitted to Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our DME formulary, please refer to "Durable Medical Equipment" in the "Benefits" section

- **Home health care.** If your Plan Physician makes a written referral for at least eight continuous hours of home health nursing or other care, Medical Group's designee physician or committee will authorize the Services if the designee determines that they are Medically Necessary
- **Ostomy and urological supplies.** If your Plan Physician prescribes ostomy or urological supplies, he or she will submit a written referral to the Plan Hospital's designated coordinator, who will authorize the item if he or she determines that the item is listed on our formulary for your condition. If the item doesn't appear to meet our soft goods formulary guidelines, then the coordinator will contact the Plan Physician for additional information about the request. If the request still doesn't appear to meet our soft goods formulary guidelines, the request will be submitted to Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our soft goods formulary, please refer to "Ostomy and Urological Supplies" in the "Benefits" section
- **Transplants.** If your Plan Physician makes a written referral for a transplant, Medical Group's regional transplant advisory committee or board (if one exists) will authorize the Services if it determines that they are Medically Necessary. In cases where no transplant committee or board exists, Medical Group will refer you to physician(s) at a transplant center, and the Medical Group will authorize the Services if the transplant center's physician(s) determine that they are Medically Necessary

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

The Copayments and Coinsurance for these referral Services are the same as those required for Services provided by a Plan Provider as described in the "Copayments and Coinsurance" 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 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 Medical Group needs more time to make the decision because it doesn't have information reasonably necessary to make the decision, or because it has requested consultation by a particular specialist, you and your treating physician will be informed about the additional information, tests, or specialist that is needed and the date 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 Medical Group does not authorize all of the Services, you will be sent a written decision and explanation within two business days after the decision is made. The letter will include information about your appeal rights, which are described in the "Dispute Resolution" section. Any written criteria 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.

**More information.** This description is only a brief summary of the authorization procedure. The policies and procedures (including a description of the authorization procedure or information about the authorization procedure applicable to some Plan Providers other than Kaiser Foundation Hospitals and Medical Group) are available upon request from our Member Service Call Center. Please refer to the "Emergency, Urgent, and Routine Care" section for authorization requirements that apply to Post-stabilization Care. Also, please refer to "Your Primary Care Plan Physician" in this "How to Obtain Services" section for the authorization requirements that apply when a Subscriber lives in Coachella Valley or western Ventura County.

## **Second Opinions**

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

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

You can either ask your Plan Physician to help you arrange for a second medical opinion, or you can make an appointment with another Plan Provider. If Medical Group determines that there isn't a Plan Provider who is an appropriately qualified medical professional for your condition, Medical Group will authorize a referral to a non-Plan Provider for a Medically Necessary second opinion. The Copayments and Coinsurance for these referral Services are the same as those required for Services provided by a Plan Provider as described in the "Copayments and Coinsurance" section.

## **Contracts with Plan Providers**

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

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

**Termination of a Plan Provider's contract.** If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

In addition, 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 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 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. The Copayments and Coinsurance for the Services of a terminated provider are the same as those required for Services provided by a Plan Provider as described in the "Copayments and Coinsurance" section. For more information about this provision, or to make a request, please call our Member Service Call Center.

## **Our Visiting Member Program**

If you visit the service area of another Region temporarily (not more than 90 days), you can receive certain Services from designated providers in that area. Coverage for these Services may differ from that in our Service Area, and is governed by our program for visiting members. This program does not cover certain Services, such as transplant or infertility Services. Also, except for covered Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care, your right to receive covered Services in the visited service area ends after 90 days unless you receive prior written authorization from us to continue receiving covered Services in the visited service area.

Please call our Member Service Call Center for more information about our visiting member program, including facility locations in other service areas. The service areas and facilities where you may obtain visiting member Services may change at any time.

## **Your Identification Card**

Each Member's Health Plan ID card has a Medical Record Number on it, which is useful when you call for advice, make an appointment, or go to a provider for covered care. Your Medical Record Number is used to identify your medical records and membership information. Your Medical Record Number should never change. Please let us know if we ever inadvertently issue you more than one Medical Record Number, or if you need to replace your ID card, by calling our Member Service Call Center.

Your ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed as a non-Member for any Services he or she receives. If you let someone else use your ID card, we may keep your ID card and terminate your membership.

## **Getting Assistance**

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

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Call Center representatives are available to assist you seven days a week (except holidays), from 7 a.m. to 7 p.m., toll free at 1-800-464-4000 (the toll-free TTY line for the hearing and speech impaired is 1-800-777-1370). For your convenience, you can also contact us through our Web site at [www.members.kp.org](http://www.members.kp.org).

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

## **Plan Facilities**

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

## **Plan Hospitals and Plan Medical Offices**

The following is a list of Plan Hospitals and most Plan Medical Offices in our Service Area. Additional Plan Medical Offices are listed in *Your Guidebook*. This list is subject to change at any time without notice. If there is

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This Evidence of Coverage is subject to change during the stated effective

a change to this list of Plan Facilities, we will update this list in any EOC issued after that date. If we terminate a contract with a Plan Hospital, we will notify Subscribers who live in the hospital's area. If you have any questions about the current locations of Plan Facilities, please call our Member Service Call Center.

**Plan Hospitals and Medical Centers (Plan Hospitals and Medical Offices)**

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

<b>City</b>	<b>Street Address</b>
<b>Anaheim</b>	Medical Centers: 441 North Lakeview Avenue 3033 West Orange Avenue (west Anaheim) Additional Plan Medical Offices: 1188 North Euclid Street 411 North Lakeview Avenue
<b>Bakersfield</b>	Plan Hospitals: 420 34th Street (Memorial Hospital) 2215 Truxtun Avenue (Mercy Hospital) 300 Old River Road (Mercy Southwest Hospital) Plan Medical Offices: 3700 Mall View Road 8800 Ming Avenue 3501 Stockdale Highway 1200 Discovery Drive
<b>Baldwin Park</b>	Medical Center: 1011 Baldwin Park Boulevard
<b>Bellflower</b>	Medical Center: 9400 East Rosecrans Avenue
<b>Escondido</b>	Plan Hospital: 555 East Valley Parkway (Palomar) Plan Medical Office: 732 North Broadway Street
<b>Fontana</b>	Medical Center: 9961 Sierra Avenue
<b>Harbor City</b>	Medical Center: 25825 South Vermont Avenue
<b>Irvine</b>	Plan Hospital: 16200 Sand Canyon Avenue (Irvine Regional Hospital) Plan Medical Office: 6 Willard Street
<b>Lancaster</b>	Plan Hospitals: 1600 West Avenue J (Antelope Valley Hospital) 43830 North 10 <sup>th</sup> Street West (Lancaster Community Hospital) Plan Medical Office: 43112 North 15 <sup>th</sup> Street West
<b>Los Angeles</b>	Medical Centers: 1526 North Edgemont Street 6041 Cadillac Avenue (west LA) Additional Plan Medical Offices: 5220 Telford Street (east LA) 5119 Pomona Boulevard (east LA) 12001 West Washington Boulevard (Culver Marina Medical Offices)
<b>Panorama City</b>	Medical Center: 13652 Cantara Street
<b>Riverside</b>	Medical Center: 10800 Magnolia Avenue

<b>City</b>	<b>Street Address</b>
<b>San Diego</b>	Medical Center: 4647 Zion Avenue Additional Plan Medical Offices: 7060 Clairemont Mesa Boulevard 4650 Palm Avenue 3250 Fordham Street 3420 Kenyon Street 3250 Wing Street 11939 Rancho Bernardo Road 4405 Vandever Avenue
<b>Woodland Hills</b>	Medical Center: 5601 De Soto Avenue

**Plan Medical Offices in other cities**

<b>City</b>	<b>Street Address</b>
<b>Aliso Viejo</b>	24502 Pacific Park Drive
<b>Bonita</b>	3955 Bonita Road
<b>Brea</b>	1900 East Lambert Road
<b>Carlsbad</b>	6860 Avenida Encinas
<b>Chino</b>	11911 Central Avenue
<b>Claremont</b>	250 West San Jose Street
<b>Colton</b>	789 South Cooley Drive
<b>Corona</b>	2055 Kellogg Avenue
<b>Cudahy</b>	7825 Atlantic Avenue
<b>Culver City</b>	5620 Mesmer Avenue
<b>Downey</b>	9449 East Imperial Highway
<b>El Cajon</b>	1630 East Main Street 250 Travelodge Drive
<b>Garden Grove</b>	12100 Euclid Street
<b>Gardena</b>	15446 South Western Avenue
<b>Glendale</b>	444 West Glenoaks Boulevard
<b>Huntington Beach</b>	18081 Beach Boulevard
<b>Inglewood</b>	110 North La Brea Avenue
<b>La Mesa</b>	8080 Parkway Drive 3875 Avocado Boulevard
<b>La Palma</b>	5 Centerpointe Drive
<b>Long Beach</b>	3900 East Pacific Coast Highway
<b>Mission Viejo</b>	23781 Maquina Avenue
<b>Montebello</b>	1550 Town Center Drive
<b>Moreno Valley</b>	12815 Heacock Street
<b>Ontario</b>	1025 West "I" Street
<b>Pasadena</b>	450 North Lake Avenue
<b>Rancho Cucamonga</b>	10850 Arrow Route
<b>Redlands</b>	25828 Redlands Boulevard
<b>San Bernardino</b>	1717 Date Place
<b>San Dimas</b>	1255 West Arrow Highway
<b>San Juan Capistrano</b>	30400 Camino Capistrano
<b>Santa Ana</b>	3401 South Harbor Boulevard 1900 East 4th Street
<b>Santa Clarita</b>	27107 Tourney Road
<b>Simi Valley</b>	3900 Alamo Street
<b>Thousand Oaks</b>	365 East Hillcrest Drive 145 Hodencamp Road
<b>Victorville</b>	14011 Park Avenue
<b>Vista</b>	780 Shadowridge Drive

City	Street Address
West Covina	1249 Sunset Avenue
Whittier	12470 Whittier Boulevard
Wildomar	36450 Inland Valley Drive
Yorba Linda	22550 East Savi Ranch Parkway

## Affiliated Plan Hospitals

<b>Western Ventura County</b>	<ul style="list-style-type: none"> <li>• St. John's Regional Medical Center at 1600 North Rose Avenue, Oxnard</li> <li>• Community Memorial Hospital of San Buenaventura at 147 North Brent Street, Ventura</li> </ul>
<b>Coachella Valley</b>	<ul style="list-style-type: none"> <li>• Desert Regional Medical Center at 1150 North Indian Canyon Drive, Palm Springs</li> <li>• Eisenhower Medical Center at 39000 Bob Hope Drive, Rancho Mirage</li> <li>• Hi-Desert Medical Center at 6601 White Feather Road, Joshua Tree</li> <li>• John F. Kennedy Memorial Hospital at 47111 Monroe Street, Indio</li> </ul>

For information about receiving care in Coachella Valley and western Ventura County, see the "Special note about Coachella Valley and western Ventura County" in the "How to Obtain Services" section. Also, please refer to *Your Guidebook* for other Plan Providers in these areas, including Affiliated Plan Physicians and Pharmacies.

### **Your Guidebook**

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

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

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

## **Emergency, Urgent, and Routine Care**

This section explains how to obtain covered Emergency Care, urgent care, Post-stabilization Care, and routine care. It also describes how our advice nurses can help assess nonemergency medical symptoms.

The care discussed in this section is not covered unless it meets the coverage requirements stated in the "Benefits" section (subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section).

## **Emergency, Urgent, and Post-stabilization Care**

### **Emergency Care**

If you have an Emergency Medical Condition, call 911 or go to the nearest hospital. When you have an Emergency Medical Condition, we cover Emergency Care from Plan Providers and non-Plan Providers anywhere in the world. An Emergency Medical Condition is:

- A medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in any of the following:
  - ◆ serious jeopardy to your health
  - ◆ serious impairment to your bodily functions
  - ◆ serious dysfunction of any bodily organ or part
- "Active labor," which means a labor when there is inadequate time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn child

**Note:** Emergency Care is available at Plan Hospital Emergency Departments listed in *Your Guidebook*. For ease and continuity of care, we encourage you to go to a Plan Hospital Emergency Department, but only if it is reasonable to do so, considering your condition or symptoms. Please refer to *Your Guidebook* for Plan Hospital Emergency Department locations in your area.

### **Urgent care**

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

**Out-of-Area Urgent Care.** If you are temporarily outside our Service Area and have an urgent care need due to an unforeseen illness or injury, we cover the Medically Necessary Services you receive from a non-Plan Provider if we find that the Services were necessary to prevent serious deterioration of your health and they could not be delayed until you returned to our Service Area.

### **Post-stabilization and follow-up care**

**Post-stabilization Care.** Post-stabilization Care is the Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable, or after you obtain covered Out-of-Area Urgent Care. We cover Post-stabilization Care only if a Plan Provider provides it or if we authorize your receiving the care from a non-Plan Provider.

To request authorization to receive Post-stabilization Care from a non-Plan Provider, you must call us at 1-800-225-8883 *before* you receive the care if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible). After we are notified, we will discuss your condition with the non-Plan Provider. If we decide that your Post-stabilization Care would be covered if you received it from a Plan Provider, we will authorize your care from the non-Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. If we decide to have a Plan Provider (or other designated 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 transportation) we have authorized since we do not cover unauthorized Post-stabilization Care provided by non-Plan Providers.

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

### **Call us!**

You must call us at **1-800-225-8883** (or the notification telephone number on your ID card) to request authorization for Post-stabilization Care *before* you obtain the care from a non-Plan Provider if it is reasonably

possible to do so (otherwise, call us as soon as reasonably possible). Also, please call us any time you are admitted to a non-Plan Hospital.

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

## **Payment and reimbursement**

If you receive Emergency Care, Out-of-Area Urgent Care, or Post-stabilization Care from a non-Plan Provider, the provider may agree to bill for the Services, or may require that you pay for the Services at that time. In either case, to request payment or reimbursement, you must file a claim as described under "Non-Plan Emergency Care, Out-of-Area Urgent Care, or Post-stabilization Care" in the "Requests for Payment or Services" section.

We will reduce any payment we make by applicable Copayments or Coinsurance, which are the same ones required for Services provided by a Plan Provider as described in the "Copayments and Coinsurance" section.

## **Routine Care**

If you need to make a routine care appointment, please refer to *Your Guidebook* for appointment telephone numbers, or log on to [www.members.kp.org](http://www.members.kp.org) to request an appointment online. Routine appointments are for medical needs that aren't urgent (such as routine checkups and school physicals). Try to make your routine care appointments as far in advance as possible.

## **Our Advice Nurses**

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

## **Benefits**

The Services described in this "Benefits" section are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the following sections about:
  - ◆ our visiting member program, in the "How to Obtain Services" section
  - ◆ Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care received from non-Plan Providers, in the "Emergency, Urgent, and Routine Care" section
- You receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary in the following sections about:
  - ◆ getting a referral, in the "How to Obtain Services" section
  - ◆ our visiting member program, in the "How to Obtain Services" section
  - ◆ Emergency Care, Out-of-Area Urgent Care, and Post-stabilization Care received from non-Plan Providers, in the "Emergency, Urgent, and Routine Care" section

Exclusions and limitations that apply only to a particular benefit are described in this "Benefits" section.

Exclusions, limitations, and reductions that apply to all benefits are described in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. Also, please refer to:

- The "Emergency, Urgent, and Routine Care" section for information about how to obtain Emergency Care, urgent care, Post-stabilization Care, and routine care

- The "Copayments and Coinsurance" section for the amounts you must pay for covered Services described in this "Benefits" section
- *Your Guidebook* for the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services

### **Outpatient Care**

We cover the following outpatient care for preventive medicine, diagnosis, and treatment:

- Primary care visits for internal medicine, gynecology (including cervical cancer screening tests and mammograms), family practice, and pediatrics
- Specialty care visits (refer to "Referrals to Plan Providers" in the "How to Obtain Services" section for information about referrals to Plan specialists)
- After confirmation of pregnancy, all Obstetrical Department prenatal visits and the first postpartum visit
- Preventive health screenings
- Outpatient surgery and anesthesia
- Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation day treatment program)
- Respiratory therapy
- Blood, blood products, and their administration
- Medical social services
- House calls inside our Service Area when care can best be provided in your home as determined by a Plan Physician
- Emergency Department visits (please refer to the "Emergency, Urgent, and Routine Care" section for information about Emergency Care and urgent care)

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

- Chemical Dependency Services
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Drugs, Supplies, and Supplements
- Durable Medical Equipment
- Family Planning Services
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Imaging, Laboratory, and Special Procedures
- Infertility Services
- Mental Health Services
- Ostomy and Urological Supplies
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- 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 in 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
- Plan Physicians' and surgeons' Services, including consultation and treatment by specialists

- Anesthesia
- Medical supplies
- Blood, blood products, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge
- Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation program in a licensed acute rehabilitation facility)
- Respiratory therapy
- Medical social services and discharge planning

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

- Chemical Dependency Services
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Drugs, Supplies, and Supplements
- Durable Medical Equipment
- Hospice Care
- Imaging, Laboratory, and Special Procedures
- Infertility Services
- Mental Health Services
- Ostomy and Urological Supplies
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Skilled Nursing Facility Care
- Transplant Services

## **Ambulance Services**

### **Emergency**

When you have an Emergency Medical Condition, we cover emergency Services of a licensed ambulance. We cover emergency ambulance Services that are not ordered by us only if one of the following is true:

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

### **Nonemergency**

We cover nonemergency ambulance Services if a Plan Physician determines your condition requires the use of Services that only a licensed ambulance can provide and the use of other means of transportation would endanger your health.

### **Ambulance Services exclusion**

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

## **Chemical Dependency Services**

### **Inpatient detoxification**

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including dependency recovery Services, education, and counseling.

## Outpatient

We cover the following Services for treatment of chemical dependency:

- Day treatment programs
- Intensive outpatient programs
- Counseling (both individual and group visits) for chemical dependency
- Medical treatment for withdrawal symptoms
- Methadone maintenance treatment for pregnant Members during pregnancy and for two months after delivery at a licensed treatment center approved by Medical Group. We do not cover methadone maintenance treatment in any other circumstances

## Transitional residential recovery Services

We cover up to 60 days per calendar year of chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by Medical Group; no more than 120 days of covered care is provided in any five consecutive calendar year period. These settings provide counseling and support services in a structured environment.

## Chemical dependency Services exclusions

- Services in a specialized facility for alcoholism, drug abuse, or drug addiction except as described above

## Dental Services for Radiation Treatment and Dental Anesthesia

### Dental Services for radiation treatment

We cover evaluation, extraction, dental X-rays, and fluoride treatment, if a Plan Physician refers you to a dentist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) to prepare your jaw for radiation treatment of cancer.

### 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 seven, 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.

## Dialysis Care

If the following criteria are met, we cover dialysis Services related to acute renal failure and end-stage renal disease:

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

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

## Drugs, Supplies, and Supplements

We cover drugs, supplies, and supplements specified in this section when prescribed by a Plan Physician (except as otherwise described under "Outpatient drugs, supplies, and supplements") and in accord with our drug formulary guidelines.

You must obtain covered drugs, supplies, and supplements from a Plan Pharmacy. Please refer to *Your Guidebook* for the location of Plan Pharmacies in your area. You may be able to order refills through our Web

site at [www.members.kp.org](http://www.members.kp.org). A Plan Pharmacy or *Your Guidebook* can give you more information about obtaining refills (for example most Plan Pharmacies offer refills by mail, whereas a few Plan Pharmacies don't dispense covered refills).

Please be aware that durable medical equipment used to administer drugs is not covered under this "Drugs, Supplies, and Supplements" section (instead, refer to the "Durable Medical Equipment" section).

### **Administered drugs, supplies, and supplements**

We cover the following during a covered stay in a Plan Hospital or Skilled Nursing Facility, or if they require administration or observation by medical personnel and are administered to you in a Plan Medical Office or during home visits:

- Drugs, injectables, internally implanted time-release contraceptives, intrauterine devices (IUDs), radioactive materials used for therapeutic purposes, vaccines and immunizations approved for use by the federal Food and Drug Administration (FDA), and allergy test and treatment materials

### **Self-administered IV drugs, supplies, and supplements**

We cover certain drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an IV or intraspinal-infusion). We also cover the supplies and equipment required for their administration. Injectable drugs, insulin, and drugs for the treatment of infertility are not covered under this paragraph (instead, refer to the "Outpatient drugs, supplies, and supplements" paragraph below).

### **Diabetes urine-testing supplies and insulin-administration devices**

We cover the following diabetes urine-testing supplies: ketone test strips and sugar or acetone test tablets or tapes. Note: Diabetes blood-testing equipment and their supplies are not covered under this "Drugs, Supplies, and Supplements" section (instead, refer to the "Durable Medical Equipment" section).

We cover the following insulin-administration devices: disposable needles and syringes, pen delivery devices, and visual aids required to ensure proper dosage (except eyewear). Note: Insulin pumps and their supplies are not covered under this "Drugs, Supplies, and Supplements" section (instead, refer to the "Durable Medical Equipment" section).

### **Outpatient drugs, supplies, and supplements**

We cover the following drugs, supplies, and supplements when prescribed by a Plan Physician or dentist (drugs, supplies, and supplements prescribed by dentists are not covered if a Plan Physician determines that they are not Medically Necessary):

- Drugs for which a prescription is required by law. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary. Note: Smoking-cessation drugs are covered if you participate in a Plan-approved behavioral intervention program
- Diaphragms, cervical caps, and oral contraceptives (including emergency contraceptive pills)
- Disposable needles and syringes needed for injecting covered drugs

### **About our drug formulary**

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

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

## Drugs, supplies, and supplements exclusions

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

**Note:** 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 FDA. You must pay a 50 percent Coinsurance.

## Durable Medical Equipment

We cover durable medical equipment (DME) in accord with our DME formulary guidelines. Coverage is limited to the standard item of equipment that adequately meets your medical needs.

### DME at a Plan Hospital or Skilled Nursing Facility

We cover equipment, including oxygen used during a covered stay in a Plan Hospital or Skilled Nursing Facility if Skilled Nursing Facilities ordinarily furnish the equipment.

### DME for home use

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

Inside our Service Area, we cover DME for use in your home (or another location used as your home inside our Service Area). If you live outside our Service Area, we do not cover most DME for use in your home, but our DME formulary guidelines allow certain DME (such as crutches and canes) for use in your home to be picked up from Plan Facilities even if you live outside our Service Area. To find out whether we will cover a particular DME item even if you live outside our Service Area, please call our Member Service Call Center.

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

### About our DME formulary

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

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

**Note:** Diabetes urine-testing supplies and insulin-administration devices (except insulin pumps) are not covered under this "Durable Medical Equipment" section (instead, refer to the "Drugs, Supplies, and Supplements" section). This section does apply to the following diabetes blood testing equipment and insulin-administration devices:

- Blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)

- Infusion pumps (such as insulin pumps) and supplies to operate the pump

### **Durable medical equipment exclusions**

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

### **Family Planning Services**

We cover the following:

- Family planning counseling, including preabortion and postabortion counseling and information on birth control
- Tubal ligations
- Vasectomies
- Voluntary termination of pregnancy

**Note:** Contraceptive drugs and devices are not covered under this "Family Planning Services" section (instead, refer to the "Drugs, Supplies, and Supplements" section).

### **Health Education**

We cover a variety of health education programs to help you protect and improve your health, including programs for smoking cessation, stress management, and chronic conditions (such as diabetes and asthma). You can also participate in programs and classes that we don't cover, which may require that you pay a fee. For more information about our health education programs, please contact your local Health Education Department or call our Member Service Call Center, or log on to [www.members.kp.org](http://www.members.kp.org). *Your Guidebook* also includes information about our health education programs.

### **Hearing Services**

We cover hearing tests to determine the need for hearing correction.

### **Hearing Services exclusions**

- Tests to determine an appropriate hearing aid
- Hearing aids or tests to determine their efficacy

### **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, or speech therapist
- 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

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

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

- Dialysis Care
- Drugs, Supplies, and Supplements
- Durable Medical Equipment
- Ostomy and Urological Supplies
- Prosthetic and Orthotic Devices

### Home health care exclusions

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

### Hospice Care

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

We cover the 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 (including a friend's or relative's home even if you live there temporarily) by a licensed hospice agency approved by Medical Group
- The Services are necessary for the palliation and management of your terminal illness and related conditions

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

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from Plan Pharmacies. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call our Member Service Call Center for the current list of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling
- The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms:
  - ◆ nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home

- ◆ short-term inpatient care required at a level that cannot be provided at home

## **Imaging, Laboratory, and Special Procedures**

We cover the following Services only when prescribed as part of care covered under other parts of this "Benefits" section (for example, diagnostic imaging and laboratory tests are covered for infertility only to the extent that infertility Services are covered under "Infertility Services"):

- Diagnostic and therapeutic imaging, such as X-rays, magnetic resonance imaging (MRI), computed tomography, and positron emission tomography
- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available
- Special procedures, such as electrocardiograms and electroencephalograms
- Ultraviolet light treatments

## **Infertility Services**

We cover the following Services:

- Services for diagnosis and treatment of involuntary infertility
- Artificial insemination (except for donor semen or eggs, and Services related to their procurement and storage)

**Note:** Diagnostic procedures are not covered under this "Infertility Services" section (instead, refer to the "Imaging, Laboratory, and Special Procedures" section). Also, drugs, supplies, and supplements are not covered under this section (instead, refer to the "Drugs, Supplies, and Supplements" section).

## **Infertility Services exclusion**

- Services to reverse voluntary, surgically induced infertility

## **Mental Health Services**

We cover mental health Services as specified below, except that any outpatient-visit and inpatient-day limits specified below do not apply to the following conditions:

- These severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa
- A Serious Emotional Disturbance (SED) of a child under 18, which means mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:
  - ◆ as a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either (a) the child is at risk of removal from home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
  - ◆ the child displays psychotic features, or risk of suicide or violence due to a mental disorder
  - ◆ the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

For all other mental health conditions, we cover evaluation, crisis intervention, and treatment only when a Plan Physician or other Plan mental health professional believes the condition will significantly improve with relatively short-term therapy.

## **Outpatient mental health Services**

We cover:

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

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- Psychological testing
- Visits for the purpose of monitoring drug therapy

### **Inpatient psychiatric care**

We cover up to 30 days of psychiatric hospitalization in a Plan Hospital each calendar year, including Services of Plan Physicians and other Plan mental health professionals. The number of covered days is reduced by the amount of any hospital alternative Services you receive as described below.

### **Hospital alternative Services**

We cover treatment in a structured multidisciplinary program as an alternative to inpatient psychiatric care. Each treatment period of hospital alternative Services will reduce the number of covered days of inpatient psychiatric hospitalization as follows:

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

**Note:** Drugs, supplies, and supplements are not covered under this "Mental Health Services" section (instead, refer to the "Drugs, Supplies, and Supplements" section).

### **Ostomy and Urological Supplies**

Inside our Service Area, we cover ostomy and urological supplies prescribed in accord with our soft goods formulary guidelines. We select the vendor and coverage is limited to the standard item of equipment that adequately meets your medical needs.

### **About our soft goods formulary**

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

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

### **Ostomy and urological supplies exclusions**

- Comfort, convenience, or luxury equipment or features

### **Prosthetic and Orthotic Devices**

We cover the devices listed below if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is not ill or injured. Also, devices are limited to the standard device that adequately meets your medical needs. We also cover enteral formula for Members who require tube feeding in accord with Medicare guidelines.

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

## **Internally implanted devices**

We cover internal devices implanted during covered surgery, such as pacemakers and hip joints, that are approved by the federal Food and Drug Administration for general use.

## **External devices**

We cover the following external prosthetics and orthotics:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres every 12 months
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan podiatrist, physiatrist, or orthopedist
- Compression burn garments and lymphedema wraps and garments
- Other covered prosthetic and orthotic devices:
  - ◆ Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
  - ◆ Rigid and semi-rigid orthotic devices required to support or correct a defective body part
  - ◆ Special footwear for foot disfigurement due to disease, injury, or developmental disability

## **Prosthetic and orthotic devices exclusions**

- Eyeglasses and contact lenses
- Hearing aids
- Dental appliances
- Except as described above, nonrigid supplies, such as elastic stockings and wigs
- Comfort, convenience, or luxury equipment or features
- Electronic voice-producing machines
- Shoes or arch supports, even if custom-made, except footwear described above for diabetes-related complications and foot disfigurement

## **Reconstructive Surgery**

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

## **Mastectomies**

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.

**Note:** Prosthetics and orthotics are not covered under this "Reconstructive Surgery" section (instead, refer to the "Prosthetic and Orthotic Devices" section).

## **Reconstructive surgery exclusions**

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

## **Services Associated with Clinical Trials**

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

- You are diagnosed with cancer
- You are accepted into a phase I, II, III, or IV clinical trial for cancer
- Your treating Plan Physician recommends participation in the clinical trial after determining that it has a meaningful potential to benefit you (non-Plan Provider Services are covered in accord with "Medical Group

authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)

- The Services would be covered under this EOC if they were not provided in connection with a clinical trial
- The clinical trial has a therapeutic intent, and its endpoints are not defined exclusively to test toxicity
- The clinical trial involves a drug that is exempt under federal regulations from a new drug application, or the clinical trial is approved by: one of the National Institutes of Health, the federal Food and Drug Administration (in the form of an investigational new drug application), the U.S. Department of Defense, or the U.S. Department of Veterans Affairs

### **Services associated with clinical trials exclusions**

- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management
- Services that are customarily provided by the research sponsors free of charge to enrollees in the clinical trial
- Services associated with the provision of drugs or devices that have not been approved by the federal Food and Drug Administration

### **Skilled Nursing Facility Care**

Inside our Service Area, we cover up to 100 days per "benefit period" of skilled inpatient Services in a licensed Skilled Nursing Facility when prescribed by a Plan Physician. The skilled inpatient Services must be Medically Necessary, customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care. A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or skilled nursing facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

We cover the following Services:

- Physician and nursing Services
- Room and board
- Medical social services
- Blood, blood products, and their administration
- Medical supplies
- Physical, occupational, and speech therapy
- Respiratory therapy

**Note:** Drugs are not covered under this "Skilled Nursing Facility Care" section (instead, refer to the "Drugs, Supplies, and Supplements" section). Durable medical equipment is not covered under this "Skilled Nursing Facility Care" section (instead, refer to the "Durable Medical Equipment" section). Also, imaging, laboratory, and special procedures are not covered under this section (instead, refer to "Imaging, Laboratory, and Special Procedures" section).

### **Transplant Services**

We cover transplants of organs, tissue, or bone marrow if 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 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, 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 Medical Group as a potential donor, even if the donor is not a Member. These Services must be directly related to a covered transplant for you. Our criteria for donor Services is available by calling our Member Service Call Center

## **Vision Services**

We cover refraction exams to determine the need for vision correction and to provide a prescription for eyeglasses. We do not cover eyeglasses or contact lenses. However, we do cover Medically Necessary contact lenses to treat aniridia (missing iris), up to two lenses per eye every 12 months when prescribed by a Plan Physician or Plan optometrist.

### **Vision Services exclusions**

- Eyeglass lenses or frames
- Contact lenses or contact lens examinations, fittings, or dispensing except as described above to treat aniridia
- Services related to eye surgery or orthokeratologic Services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism

## **Exclusions, Limitations, Coordination of Benefits, and Reductions**

### **Exclusions**

The Services listed below are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this EOC. Additional exclusions that apply only to a particular Service are listed in the description of that Service in the "Benefits" section.

#### **Certain exams and Services**

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

#### **Chiropractic Services**

Chiropractic Services and the Services of a chiropractor.

#### **Conception by artificial means**

All Services (other than artificial insemination described under "Infertility Services" in the "Benefits" section) related to conception by artificial means, such as: ovum transplants, gamete intrafallopian transfer (GIFT), donor semen or eggs (and Services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

#### **Cosmetic Services**

Services that are intended primarily to improve your appearance, except for Services covered under "Reconstructive Surgery" and prostheses needed after a mastectomy covered under "Prosthetic and Orthotic Devices" in the "Benefits" section.

#### **Custodial care**

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

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

#### **Dental care**

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

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## **Experimental or investigational Services**

A Service is experimental or investigational if we, in consultation with Medical Group, determine that:

- 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), or
- It requires government approval that has not been obtained when the Service is to be provided

This exclusion does not apply to Services covered under "Services Associated with Clinical Trials" 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**

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 "Hospice Care" in the "Benefits" section.

## **Routine foot care Services**

Routine foot care Services that are not Medically Necessary.

## **Services related to a noncovered Service**

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

## **Sexual reassignment surgery**

## **Speech Therapy**

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

## **Surrogacy**

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

## **Travel and lodging expenses**

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

## **Limitations**

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

## **Coordination of Benefits (COB)**

The Services covered under this *EOC* are subject to coordination of benefits (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB 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% of your covered medical expenses are paid for that Service. The COB 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 the calendar year to pay for your out-of-pocket expenses for Services that are partially covered by either your other coverage or us. 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 COB, please call our Member Service Call Center.

## **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**

You must pay us Charges for covered Services you receive for an injury or illness that is alleged to be caused by a third party's act or omission, except that you do not have to pay us more than you receive from or on behalf of the third party.

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

To secure our rights, we will have a lien on the proceeds of any judgment or settlement you 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 recovery is less than the actual losses and damages you incurred.

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

Kaiser Permanente  
Special Recovery Unit-8553  
Parsons East, 2nd Floor  
P.O. Box 7017  
Pasadena, CA 91109-9977

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  
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forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You must not take any action prejudicial to our rights.

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

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

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers ordinarily charge to the general public ("General Fees"). However, these contracts may allow the providers to assert any independent lien rights they may have to recover their General Fees from a judgment or settlement that you receive from or on behalf of a third party. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

### **Medicare benefits**

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

### **Surrogacy arrangements**

You must pay us Charges for covered Services you receive related to conception, pregnancy, or delivery in connection with a surrogacy arrangement ("Surrogacy Health Services"). Your obligation to pay us for Surrogacy Health Services is limited to the compensation you are entitled to receive under the surrogacy arrangement. A surrogacy arrangement is one in which you agree to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

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

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

Kaiser Permanente  
Special Recovery Unit  
Parsons East, 2nd Floor  
P.O. Box 7017  
Pasadena, CA 91109-9977  
Attention: Third Party Liability Supervisor

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy arrangements" section and to satisfy those rights. You must not take any action prejudicial to our rights.

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

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

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

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

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

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

## **Requests for Payment or Services**

### **Requests for Payment**

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

If you receive Emergency Care, Out-of-Area Urgent Care, or Post-stabilization Care from a non-Plan Provider as described in the "Emergency, Urgent, and Routine Care" section, you must file a claim if you want us to pay for the Services. This is what you need to do:

- As soon as possible, get our claim form by calling our Member Service Call Center toll free at 1-800-464-4000 or 1-800-390-3510
- If you have paid for the Services, you must send us our completed claim form for reimbursement. Please attach any bills from the non-Plan Provider and receipts
- To request that a non-Plan Provider be paid for Services, you must send us our completed claim form and include any bills from the non-Plan Provider. If the non-Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the non-Plan Provider, please call our Member Service Call Center toll free at 1-800-390-3510, to confirm that we have received everything we need
- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled
- The completed claim form must be mailed to the following address as soon as possible after receiving the care. Any additional information we request should also be mailed to this address:

Kaiser Foundation Health Plan, Inc.  
Claims Department  
P.O. Box 7102  
Pasadena, CA 91109-9880

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

If we deny your claim in whole or in part, we will send you a written decision that fully explains why we denied it and how you can file a grievance.

### **Other Services**

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

We will send you our written decision within 30 days unless we notify you, within that initial 30 days, that we need additional information from you or the non-Plan Provider. We must receive the additional information within 45 days of our request in order for the information to be considered in our decision. We will send you our

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

If we deny your request in whole or in part, our written decision will fully explain why we denied it and how you can file a grievance.

## **Requests for Services**

### **Standard decision**

Plan Providers make the decision about which Services are right for you. If you have received a written denial of Services from Medical Group or a "Notice of Non-Coverage" and you want to request that we cover the Services, you can file a grievance as described in the "Dispute Resolution" section.

If you haven't received a written denial of Services, you may make a request for Services orally or in writing to your local Member Services Department at a Plan Facility. You will receive a written decision within 15 days unless you are notified that additional information is needed. The additional information must be received within 45 days of the request for information in order for it to be considered in the decision. You will receive a written decision within 15 days of our receipt of the additional information. If you don't supply the additional information within 45 days of the request, you will receive a written decision no later than 75 days after the date you made your request to Member Services. If your request is denied in whole or in part, the written decision will fully explain why your request was denied and how you can file a grievance.

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

### **Expedited decision**

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

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

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

- Call toll free 1-888-987-7247
- Send your written request to Kaiser Foundation Health Plan, Inc., Advocacy Program, P.O. Box 12983, Oakland, CA 94604-2983, Attention: Expedited Review
- Fax your written request to 1-888-987-2252
- Deliver your request in person to your local Member Services Department at a Plan Facility

If we deny your request for an expedited decision, we will notify you and we will respond to your request for coverage as described under "Standard decision." If we deny your request for coverage in whole or in part, our written decision will fully explain why we denied it and how you can file a grievance.

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

# Dispute Resolution

## Grievances

We are committed to providing you with quality care and with a timely response to your concerns if an issue arises. Our Member Service representatives are available to discuss your concerns at most Plan Facilities or you can call our Member Service Call Center.

You can file a grievance for any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about Services you received. You may submit your grievance orally or in writing as follows:

- To a Member Service representative at your local Member Services Department at a Plan Facility (please refer to *Your Guidebook* for locations)
- Through our Web site at [www.members.kp.org](http://www.members.kp.org)
- To the following location for claims described under "Non-Plan Emergency Care, Out-of-Area Urgent Care, or Post-stabilization Care" in the "Requests for Payment or Services" section:  
Kaiser Permanente  
Special Services Unit  
P.O. Box 7136  
Pasadena, CA 91109

We will send you a confirming letter within five days of our receipt of your grievance. We will send you our written decision within 30 days. If we deny your grievance in whole or in part, our written decision will fully explain why we denied it and additional dispute resolution options.

## **Expedited grievance**

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

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

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

- Call toll free 1-888-987-7247
- Send your written request to Kaiser Foundation Health Plan, Inc., Advocacy Program, P.O. Box 12983, Oakland, CA 94604-2983, Attention: Expedited Review
- Fax your written request to 1-888-987-2252
- Deliver your request in person to your local Member Services Department at a Plan Facility

If we deny your request for an expedited decision, we will notify you and we will respond to your grievance within 30 days. If we deny your grievance in whole or in part, our written decision will fully explain why we denied it and additional dispute resolution options.

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

## **Providing Supporting Documents for Your Request**

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

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## Who May File

The following persons may file a grievance:

- You may file for yourself
- You may appoint someone as your authorized representative by completing our authorization form. Authorization forms are available from your local Member Services Department at a Plan Facility or by calling our Member Service Call Center. Your completed authorization form must accompany the grievance
- You may file for your Dependent children, except that they must appoint you as their authorized representative if they have the legal right to control release of information that is relevant to the grievance
- You may file for your ward if you are a court-appointed guardian
- You may file for your conservatee if you are a court-appointed conservator
- You may file for your principal if you are an agent under a health care proxy, to the extent provided under state law
- Your physician may request an expedited grievance as described under "Expedited grievance" above

## DMHC Complaints

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

## Independent Medical Review (IMR)

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

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

- One of these situations applies to you: (1) you have a recommendation from a provider requesting Medically Necessary Services, (2) you have received Emergency Care or urgent care from a provider who determined the Services to be Medically Necessary, or (3) you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment or a Service has been denied, modified, or delayed based in whole or in part on a decision that the Service is not Medically Necessary
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for expedited grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function

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

If DMHC determines that your case is eligible for IMR, it will ask us to send your case to the DMHC's Independent Medical Review organization. The DMHC will promptly notify you of its decision after it receives the

Independent Medical Review organization's determination. If the decision is in your favor, we will contact you to arrange for the Service or payment.

### **Experimental or investigational denials**

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

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested
  - ◆ "life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival
  - ◆ "seriously debilitating" means diseases or conditions that cause major irreversible morbidity
- If your treating physician is a Plan Physician, he or she recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying his or her recommendation
- You (or your non-Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the physician in certifying his or her recommendation. We do not cover the Services of the non-Plan Provider

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

### **Binding Arbitration**

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

1. 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, for premises liability, or relating to the coverage for, or delivery of, Services, irrespective of the legal theories upon which the claim is asserted
2. 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
3. The claim is *not* within the jurisdiction of the Small Claims Court
4. If the Member's Group must comply with the Employee Retirement Income Security Act (ERISA) requirements, the claim is *not* a benefit-related request that constitutes a "benefit claim" in Section 502(a)(1)(B) of ERISA. Note: Benefit claims under this Section of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice

As referred to in this "Binding Arbitration" section,

1. "Member Parties" include:
  - a. A Member,

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- b. A Member's heir or personal representative, or
  - c. Any person claiming that a duty to him or her arises from a Member's relationship to one or more Kaiser Permanente Parties.
2. "Kaiser Permanente Parties" include:
- a. Kaiser Foundation Health Plan, Inc. (Health Plan),
  - b. Kaiser Foundation Hospitals (KFH),
  - c. The Permanente Medical Group, Inc. (TPMG),
  - d. Southern California Permanente Medical Group (SCPMG),
  - e. The Permanente Federation, LLC,
  - f. The Permanente Company, LLC,
  - g. Any KFH, TPMG, or SCPMG physician,
  - h. Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties, or
  - i. Any employee or agent of any of the foregoing.
3. "Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above.
4. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

### **Arbitration Oversight Board and Independent Administrator**

In 1997, Health Plan assembled a Blue Ribbon Panel to evaluate the arbitration system and recommend improvements. The Panel's recommendations included the establishment of an Independent Administrator to oversee the arbitration process and an Advisory Committee with broad representation to assist in the independent administration. The Independent Administrator and the Advisory Committee established Rules of Procedure applicable to Health Plan's arbitration system. In 2002, the Advisory Committee was replaced by an Arbitration Oversight Board.

### **Initiating Arbitration**

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

### **Serving Demand for Arbitration**

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

Kaiser Foundation Health Plan, Inc.  
Legal Department  
393 East Walnut Street  
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, non-refundable, 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 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 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 the Kaiser Permanente Member Service Call Center.

## **Number of Arbitrators**

The number of Arbitrators may affect the Claimant's responsibility for paying the Neutral Arbitrator's fees and expenses.

If the Demand for Arbitration seeks total damages of \$200,000 or less, the dispute shall be heard and determined by one Neutral Arbitrator, unless the parties otherwise agree in writing that the arbitration shall be heard by two Party Arbitrators and a 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 Arbitrator Fees and Expenses**

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

If the parties select Party Arbitrators, Claimants shall be responsible for paying the fees and expenses of their Party Arbitrator and Respondents shall be responsible for paying the fees and expenses of their Party Arbitrator.

## **Costs**

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

## **Rules of Procedure**

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

## **General Provisions**

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

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

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this section.

## Termination of Membership

Your 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, 2004, your last minute of coverage was at 11:59 p.m. on December 31, 2003). 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 meet the eligibility requirements described under "Who Is Eligible" in the "Dues, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month. For example, if you become ineligible on December 5, 2003, your termination date is January 1, 2004 and your last minute of coverage is at 11:59 p.m. on December 31, 2003.

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

- Your behavior threatens the safety of Plan personnel, or of any person or property at a Plan Facility
- You commit theft from Health Plan, from a Plan Provider, or at a Plan Facility
- You knowingly commit fraud in connection with membership, Health Plan, or a Plan Provider. Some examples of fraud include:
  - ◆ misrepresenting eligibility information about you or a dependent
  - ◆ presenting an invalid prescription or physician order
  - ◆ misusing a Health Plan ID card (or letting someone else use it)
  - ◆ giving us incorrect or incomplete material information
  - ◆ failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits

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

### Termination for Nonpayment

#### **Nonpayment of Dues**

If your Group fails to pay us the appropriate Dues for your Family Unit, we may terminate the memberships of everyone in your Family Unit.

**Partial payment of Dues for a Family Unit.** If your Group makes a partial Dues payment specifically for your Family Unit and does not pay us the entire Dues required for your Family Unit, we will terminate the memberships of everyone in the Family Unit at 11:59 p.m. on the last day of the month in which our determination is made. We will send written notice of the termination to the Subscriber at least 15 days before the termination date. Also, if we terminate your membership, we will reinstate your membership without a lapse in coverage, if we receive full payment from your Group on or before your Group's next scheduled payment due date.

For Members who are eligible for Medicare as primary coverage, Dues are based on the assumption that Health Plan or its designee will receive Medicare payments for Medicare-covered Services provided to Members

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eligible for benefits under Medicare Part A or Part B (or both). If you are or become eligible for Medicare as primary coverage, you must comply with the following requirements:

- Enroll in all parts of Medicare for which you are eligible and continue that enrollment while a Member
- Be enrolled through your Group in Kaiser Permanente Senior Advantage
- Complete and submit all documents necessary for Health Plan, or any provider from whom you receive Services covered by Health Plan, to obtain Medicare payments for Medicare-covered Services provided to you

If you do not comply with all of these requirements for any reason, even if you are unable to enroll in Kaiser Permanente Senior Advantage because you do not meet the plan's eligibility requirements, the plan is not available through your Group, or Senior Advantage is closed to enrollment, we will increase your Group's Dues to compensate for the lack of Medicare payment and transfer your membership to our non-Medicare plan if you are not already so enrolled. However, if your Group does not pay us the entire Dues required for your Family Unit, we will terminate the memberships of everyone in the Family Unit in accord with this section.

**Note:** Medicare is the primary coverage except when federal law requires that Group's health care plan be primary and Medicare coverage be secondary.

### **Nonpayment of any other charges**

We may terminate your membership if you fail to pay any amount you owe Health Plan or a Plan Provider. We will send written notice of the termination to the Subscriber at least 15 days before the termination date. If we receive full payment before the termination date, we will not terminate your membership. Also, if we terminate your membership for nonpayment of other charges, we will reinstate your membership without a lapse in coverage if we receive full payment on or before the next scheduled payment due date.

Persons whose memberships are terminated for nonpayment of other charges may not enroll in Health Plan unless all amounts owed have been paid, and then, only if we approve the enrollment.

### **Termination of a Product or all Products**

We may terminate a particular product or all products offered in a small or large group market as permitted by law. If we discontinue offering a particular product in a market, we will terminate just the particular product upon 90 days prior written notice to you. If we discontinue offering all products to groups in a small or large group market, as applicable, we may terminate the *Group Agreement* upon 180 days prior written notice to you.

### **Certificates of Creditable Coverage**

The Health Insurance Portability and Accountability Act requires employers or health plans to issue "Certificates of Creditable Coverage" to terminated group Members. The certificate documents health care membership and is used to prove prior creditable coverage when a terminated Member seeks new coverage. When your membership terminates, we will mail the certificate to the Subscriber unless your Group has an agreement with us to mail the certificates. If you have any questions, please contact your Group's benefits administrator.

### **Payments after Termination**

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

- Refund any amounts we owe your Group for Dues paid for the period after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with "Non-Plan Emergency Care, Out-of-Area Urgent Care, or Post-stabilization Care" in the "Requests for Payment or Services" section. Any amounts you owe Health Plan, Kaiser Foundation Hospitals, or Medical Group will be deducted from any payment we make to you

### **State Review of Membership Termination**

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

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## Continuation of Membership

If your membership under this *EOC* ends, you may be eligible to maintain Health Plan membership without a break in coverage under this *EOC* (group coverage) or you may be eligible to convert to an individual (nongroup) plan.

### Continuation of Group Coverage under 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 COBRA law. COBRA applies to employees (and their covered family Dependents) of most employers with 20 or more employees. Members are not ineligible for COBRA continuation coverage solely because they live in the service area of a Region outside California.

You must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group's benefits administrator for the details about COBRA continuation coverage, such as how to elect coverage and how much you must pay your Group.

As described in "Conversion of Group Membership to an Individual Plan," you may be able to convert to an individual (nongroup, including HIPAA) plan if you don't apply for COBRA coverage, or if you enroll in COBRA and your COBRA coverage ends. Also, 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 in "Cal-COBRA after exhausting COBRA" and "State Continuation Coverage after COBRA or Cal-COBRA coverage."

### **Cal-COBRA after exhausting COBRA**

In certain cases, if you would otherwise lose COBRA coverage, you may be able to continue uninterrupted Group coverage under this *EOC* for a limited time upon arrangement with us in compliance with Cal-COBRA 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 are not entitled to Medicare
- You pay us the monthly dues by the billing due date described under "How to request enrollment and paying dues"

As described in "Conversion of Group Membership to an Individual Plan," you may be able to convert to an individual (nongroup) plan if you don't apply for Cal-COBRA coverage, or if you enroll in Cal-COBRA and your Cal-COBRA coverage ends. Also, if you enroll in Cal-COBRA and exhaust the time limit for Cal-COBRA coverage, you may be able to continue Group coverage under state law as described under "State Continuation Coverage after COBRA or Cal-COBRA coverage."

**How to request enrollment and paying dues.** Within 63 days of the date of our termination letter, or of your membership termination date (whichever date is later), you must request an enrollment application by calling our Member Service Call Center. Within 10 days of your request, we will send you our enrollment application, which will include dues and billing information. You must return your completed application promptly.

If we approve your enrollment application, we will send you a bill within 30 days after we receive your application. You will have 45 days to pay the bill. The first dues payment will include coverage from when you exhausted COBRA coverage through our current billing cycle. If you do not send us the dues payment by the due date on the bill, you will not be enrolled in Cal-COBRA.

Thereafter, monthly dues payments are due on or before the last day of the month preceding the month of coverage. The dues will not exceed 110% of the applicable Dues for covered employees except for disabled individuals. For Dependents, the dues will not exceed 110% of the applicable Dues charged to a similarly situated individual under the group benefit plan except for disabled individuals. In the case of disabled individuals after 18 months of COBRA coverage, the percentage is 150% instead of 110%.

**Termination of Cal-COBRA continuation coverage.** Cal-COBRA coverage continues only upon payment of applicable monthly dues 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 become entitled to 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)
- Expiration of 36 months after your original COBRA effective date (under this or any other plan)
- If we do not receive your entire dues payment on or before the last day of the month preceding the month of coverage, we will send written notice of the termination to the Subscriber at least 15 days before the termination date. You are responsible for paying all Dues for the period prior to the termination date. If we receive full payment before the termination date, we will not terminate your membership. Also, if we terminate your membership for nonpayment of Dues, we will reinstate your membership without a lapse in coverage if we receive full payment on or before the next scheduled payment due date following the one you missed

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: (i) expiration of 36 months after your original COBRA effective date, or (ii) 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.

**Open enrollment or termination of another health plan.** If you previously elected Cal-COBRA coverage through another health plan available through 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.

To continue your Cal-COBRA coverage with us, you must request an enrollment application during your Group's open enrollment period, or within 63 days of receiving the termination notice described below from your Group. To request an application, please call our Member Service Call Center. We will send you our enrollment application and you must return your completed application promptly. If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You will have 45 days to pay the bill. If you do not send us the dues payment by the due date on the bill, you will not be enrolled in Cal-COBRA.

Note: If your Group's agreement with a health plan is terminated, the 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 plan offered by Group. It must also include information about benefits, dues, payment instructions, and enrollment forms (including instructions on how to continue Cal-COBRA coverage under the new plan). Group is required to send this information to the person's last known address, as provided by the prior plan. Health Plan is not obligated to provide this information to qualified beneficiaries if Group fails to provide the notice.

### **State Continuation Coverage after COBRA or Cal-COBRA coverage**

If you lose eligibility for COBRA or Cal-COBRA coverage because you exhaust the time limit for coverage, you may be eligible to continue your Group coverage for a limited time under state law (State Continuation Coverage) if required by Section 1373.621 of the California Health and Safety Code.

To enroll in State Continuation Coverage, you must request enrollment by calling our Member Service Call Center within 30 days before your COBRA or Cal-COBRA coverage is exhausted and meet one of the following requirements:

- You are a Subscriber, and on the date your employment with Group ended you were at least 60 years old and had been employed by Group for at least five years; or you are the Spouse of such a Subscriber

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- You are the Spouse of a Subscriber who dies, legally separates, or becomes entitled to Medicare
- You are a former Spouse of a Subscriber

### Dues

You must send us the first dues payment within 45 days of the date you send us your completed application requesting this coverage. The first payment will include coverage from when you exhausted COBRA or Cal-COBRA coverage through our current billing cycle. If you do not send us the dues payment within 45 days, you will not be enrolled in State Continuation Coverage.

The dues under this plan are different from those under COBRA and Cal-COBRA. The dues will not exceed 213% of the applicable Dues for a similarly situated individual under the group benefit plan.

### Termination of State Continuation Coverage

Coverage terminates on the earliest of:

- The date your Group's Agreement with us terminates
- The date you obtain coverage under any other group health plan not maintained by your Group, regardless of whether that coverage is less valuable
- The date you become entitled to Medicare
- Your 65th birthday
- Five years from the date your COBRA or Cal-COBRA coverage was scheduled to end, if you are a Subscriber's Spouse or former Spouse
- If we do not receive your entire dues payment on or before the last day of the month preceding the month of coverage, we will send written notice of the termination to the Subscriber at least 15 days before the termination date. You are responsible for paying all Dues for the period prior to the termination date. If we receive full payment before the termination date, we will not terminate your membership. Also, if we terminate your membership for nonpayment of Dues, we will reinstate your membership without a lapse in coverage if we receive full payment on or before the next scheduled payment due date following the one you missed

If you do not elect State Continuation Coverage, you may be able to convert to an individual (nongroup) plan as described in "Conversion of Group Membership to an Individual Plan." For more information, call our Member Service Call Center.

### Uniformed Services Employment and Reemployment Rights Act (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 USERRA law. Members are not ineligible for USERRA continuation coverage solely because they live in the service area of a Region outside California. You must submit an USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage and how much you must pay your Group.

### Conversion of Group Membership to an Individual Plan

Your Group is required to inform the Subscriber of the date your coverage ends (please check with your Group's benefits administrator to confirm your membership termination date). After your Group notifies us to terminate your membership, we will send a termination letter to the Subscriber's address of record. The letter will include information about options that may be available to you to remain a Health Plan member.

### Kaiser Permanente Individual (Conversion) Plan

If you want to remain a Health Plan member, one option that may be available is an individual plan called "Kaiser Permanente Individual (Conversion) Plan." The dues and coverage under our Individual (Conversion) Plan will differ from those under this EOC. You may be eligible to enroll in our Individual (Conversion) Plan if you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Dues, Eligibility, and Enrollment" section. Also, if you enroll in Group continuation coverage through COBRA, Cal-COBRA, USERRA, or State Continuation Coverage after COBRA or Cal-COBRA coverage, you may be eligible to enroll in our Individual (Conversion) Plan when your Group continuation coverage ends.

To be eligible for our Individual (Conversion) Plan, there must be no lapse in your coverage and you must request an enrollment application by calling our Member Service Call Center within 63 days of the date of our termination letter, or of your membership termination date, whichever date is later. We will send you our enrollment application and you must return your completed application promptly. If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You will have 45 days to pay the bill. Because your coverage under our Individual (Conversion) Plan begins when your Group coverage ends (including Group continuation coverage), your first payment to us will include coverage from when your Group coverage ended through our current billing cycle. If you do not send us the dues payment by the due date on the bill, you will not be enrolled in our Individual (Conversion) Plan.

You may not convert to our Individual (Conversion) Plan if any of the following is true:

- You continue to be eligible for coverage through your Group (but not counting COBRA, Cal-COBRA, USERRA, or State Continuation Coverage after COBRA or Cal-COBRA coverage)
- Your membership ends because our *Agreement* with your Group terminates and it is replaced by another plan within 15 days of the termination date
- We terminated your membership under "Termination for Cause" or "Nonpayment of any other charges"
- You live in the service area of a Region outside California, except that the Subscriber's or the Subscriber's Spouse's otherwise eligible children are not ineligible to be covered Dependents solely because they live in a non-California Region (please refer to the "Who Is Eligible" in the "Dues, Eligibility, and Enrollment" section for more information)

### **HIPAA and other individual plans**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health coverage for workers and their families when they change or lose their jobs. If you lose group health coverage and meet certain criteria, you are entitled to purchase individual (nongroup) health coverage from any health plan that sells individual health coverage.

Every health plan that sells individual health coverage must offer individual coverage to an eligible person under HIPAA. The health plan cannot reject your application if you are an eligible person under HIPAA, you agree to pay the required premiums, and you live or work inside the plan's service area. To be considered an eligible person under HIPAA you must meet the following requirements:

- You have 18 or more months of creditable coverage without a break of 63 days or more between any of the periods of creditable coverage or since the most recent coverage was terminated
- Your most recent creditable coverage was under a group, government, or church plan (COBRA and Cal-COBRA are considered group coverage)
- You were not terminated from your most recent creditable coverage due to nonpayment of dues or fraud
- You are not eligible for coverage under a group health plan, Medicare, or Medicaid (Medi-Cal)
- You have no other health coverage
- You have elected and exhausted any continuation coverage you were offered under COBRA or Cal-COBRA

For more information (including dues and complete eligibility requirements), please refer to the KP HIP *EOC* (the Kaiser Permanente HIPAA Individual Plan). To request a copy of the KP HIP *EOC* or for information about other individual plans, such as Kaiser Permanente Personal Advantage, please call our Member Service Call Center.

### **Coverage for a Disabling Condition if Your Group's Agreement Terminates**

If you became totally disabled after December 31, 1977, 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, coverage for your disabling condition will continue until any one of the following events occur:

- 12 months have elapsed
- You are no longer 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 Copayments and Coinsurance.

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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 Call Center, within 30 days of the date your Group's *Agreement* with us terminates.

## Miscellaneous Provisions

### Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the *Group Agreement* and 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:

- 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 made a part of your medical chart

For additional information about advance directives, including how to obtain forms and instructions, contact your local Member Services Department at a Plan Facility.

### Agreement 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*.

### 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 the *Group 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.

### Attorneys' fees and expenses

In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys' fees and other expenses.

## **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 Health Plan's agents**

Neither your Group nor any Member is the agent or representative of Health Plan.

## **Health Insurance Counseling and Advocacy Program (HICAP)**

For additional information concerning covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number, 1-800-434-0222 (*TTY 1-800-722-3140*), for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

## **Named fiduciary**

Under our *Agreement* with your Group, we have assumed the role of a "named fiduciary," a party responsible for determining whether you are entitled to benefits under this *EOC*. Also, as a named fiduciary, 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*.

## **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.

## **Nondiscrimination**

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

## **Notices**

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Service Call Center, as soon as possible to give us their new address. If a Member does not reside with the Subscriber, he or she should contact our Member Service Call Center to discuss alternate delivery options.

## **Overpayment recovery**

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

## **Privacy practices**

Kaiser Permanente will protect the privacy of your Protected Health Information (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, Social Security number, or other information that reveals who you are. You may generally see and receive copies of your PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

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

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

## Definitions

The following terms, when capitalized and used in any part of this *EOC*, mean:

**Charges:** Charges means the following:

- For Services for which the provider is compensated on a capitation basis, the charges in the provider's schedule of charges for Services provided to the general public (or, for Members, the provider's schedule of charges for Services provided to Members, if different)
- For items covered under "Drugs, supplies, and supplements" and 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 made for the Services

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

**Coinsurance:** A percentage of Charges that you must pay when you receive a covered Service as listed in the "Copayments and Coinsurance" section.

**Copayment:** A specific dollar amount that you must pay when you receive a covered Service as listed in the "Copayments and Coinsurance" section.

**Dependent:** A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible").

**Dues:** Periodic membership charges paid by Group.

**Emergency Care:** Emergency Care is:

- Evaluation by a physician (or other appropriate personnel under the supervision of a physician to the extent provided by law)
- Medically Necessary Services required to make you Clinically Stable within the capabilities of the facility
- Emergency ambulance Services covered under "Ambulance Services" in the "Benefits" section

**Emergency Medical Condition:** An Emergency Medical Condition is:

- A medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in any of the following:
  - ◆ serious jeopardy to your health
  - ◆ serious impairment to your bodily functions
  - ◆ serious dysfunction of any bodily organ or part
- "Active labor," which means a labor when there is inadequate time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to the health and safety of the Member or unborn child

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

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

**Kaiser Permanente:** Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and 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:** A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

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

**Out-of-Area Urgent Care:** An urgent care need requires prompt medical attention, but is not an Emergency Medical Condition. Out-of-Area Urgent Care is Medically Necessary Services you receive from a non-Plan Provider for an unforeseen illness or injury if all of the following are true:

- You are temporarily outside of our Service Area
- The Services are necessary to prevent serious deterioration of your health
- Treatment cannot be delayed until you return to our Service Area

**Plan:** Kaiser Permanente.

**Plan Facility:** Any facility listed in the "Plan Facilities" section or in one of the *Guidebooks* for our Service Area, except that Plan Facilities are subject to change at any time without notice. If you have any questions about the current locations of Plan Facilities, please call our Member Service Call Center.

**Plan Hospital:** Any hospital listed in the "Plan Facilities" section or in one of the *Guidebooks* for our Service Area, except that Plan Hospitals are subject to change at any time without notice. If you have any questions about the current locations of Plan Hospitals, please call our Member Service Call Center.

**Plan Medical Office:** Any medical office listed in the "Plan Facilities" section or in one of the *Guidebooks* for our Service Area, except that Plan Medical Offices are subject to change at any time without notice. If you have any questions about the current locations of Plan Medical Offices, please call our Member Service Call Center.

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

**Plan Physician:** Any licensed physician who is a partner or employee of 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, Plan Physician, Medical Group, Plan Pharmacy, or other health care provider that we designate as a Plan Provider.

**Post-stabilization Care:** Post-stabilization Care is the Services (including transportation) you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable, or after you obtain covered Out-of-Area Urgent Care. Post-stabilization Care can be provided while you are still in a hospital Emergency Department, after you have been admitted to a hospital, or in another setting.

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

**Service Area:** The following counties are entirely inside our Service Area: Orange and Los Angeles (except ZIP code 90704). Portions of the following counties, as indicated by the ZIP codes below, are also inside our Service Area:

- Imperial: 92274-75\*
- Kern: 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93250-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380-90, 93501-02, 93504-05, 93518-19, 93531, 93536, 93560-61, 93581
- Riverside: 91752, 92201-03\*, 92210-11\*, 92220, 92223, 92230\*, 92234-36\*, 92240-41\*, 92253-55\*, 92258\*, 92260-64\*, 92270\*, 92274\*, 92276\*, 92282\*, 92292\*, 92320, 92324, 92373, 92399, 92501-09, 92513-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92595-96, 92599, 92860, 92877-83
- San Bernardino: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758, 91761-64, 91766, 91784-86, 91798, 92252\*, 92256\*, 92268\*, 92277-78\*, 92284-86\*, 92305, 92307-08, 92313-18, 92321-22, 92324-26, 92329, 92333-37, 92339-41, 92345-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-94, 92397, 92399, 92401-08, 92410-15, 92418, 92420, 92423-24, 92427, 92880
- San Diego: 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-47, 91950-51, 91962-63, 91976-80, 91987, 91990, 92007-09, 92013-14, 92018-27, 92029-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-58, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-85, 92090-93, 92096, 92101-24, 92126-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-79, 92182, 92184, 92186-87, 92190-99
- Tulare: 93238, 93261
- Ventura: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07\*, 93009\*, 93010-12, 93015-16, 93020-21, 93022\*, 93030-36\*, 93040, 93041-44\*, 93060-61\*, 93062-66, 93093-94, 93099

\*Subscribers residing in Coachella Valley and western Ventura County ZIP codes are required to select a primary care Plan Physician (Affiliated Physician). Please refer to "Your Primary Care Plan Physician" in the "How to Obtain Services" section for details.

**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. Post Office.

**Services:** Health care services or items.

**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 and approved by Health Plan. 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 a convalescent nursing home, rest facility, or facility for the aged that furnishes 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 Plan Hospital) as long as it continues to meet the definition above.

**Spouse:** Your legal husband or wife. For the purposes of this EOC, the term "Spouse" includes your domestic partner, in accord with your Group's requirements that we approve in writing.

**Subscriber:** A Member who is eligible for membership on his or her 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 "Dues, Eligibility, and Enrollment" section).

## Copayments and Coinsurance

This section discusses Copayments and Coinsurance only. It does not describe benefits. To learn what is covered for each benefit (including any visit and day limits), please refer to the identical heading in the "Benefits" section (also refer to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section, which applies to all benefits).

Copayments or Coinsurance are due when you receive the Service, but for items ordered in advance, you pay the Copayment or Coinsurance in effect on the order date (though we will not cover the item unless you still

have coverage for it on the date you receive it). In some cases, we may agree to bill you for your Copayment or Coinsurance. If we agree to bill you, we will increase the amount by \$13.50 and mail you a bill for the entire amount.

<b>Outpatient care</b>	<b>You Pay</b>
Primary and specialty care visits (includes routine and urgent care appointments)	\$10 per visit
Well-child preventive care visits (23 months or younger)	No charge
Scheduled prenatal care and first postpartum visit	No charge
Outpatient surgery	\$10 per procedure
Allergy testing visits	\$10 per visit
Allergy injection visits	\$5 per visit
Physical, occupational, and speech therapy	\$10 per visit
Multidisciplinary rehabilitation program	\$10 per day
Emergency Department visits	\$50 per visit (waived if admitted directly to the hospital)
Blood, blood products, and their administration	No charge
<b>Hospital inpatient care</b>	<b>You Pay</b>
Hospital inpatient care, including physician Services	No charge
Multidisciplinary rehabilitation program in an acute rehabilitation facility	No charge
<b>Ambulance Services</b>	<b>You Pay</b>
Emergency ambulance Services	\$50 per trip
Nonemergency ambulance Services	No charge
<b>Chemical dependency Services</b>	<b>You Pay</b>
Inpatient detoxification	No charge
Outpatient individual therapy visits	\$10 per visit
Outpatient group therapy visits	\$5 per visit
Transitional residential recovery Services	\$100 per admission
<b>Dental Services for radiation treatment and dental anesthesia</b>	<b>You Pay</b>
Dental Services for radiation treatment	\$10 per visit
Dental anesthesia	The amount you would pay for hospital inpatient care or outpatient surgery, depending on the setting
<b>Dialysis care</b>	<b>You Pay</b>
Inpatient care	No charge
Physician office visits	\$10 per visit
Dialysis treatment visits	\$10 per visit
<b>Drugs, supplies, and supplements</b>	<b>You Pay</b>
Items described in the "Benefits" section under the heading "Administered drugs, supplies, and supplements" and "Self-administered IV drugs, supplies, and supplements"	No charge
Diabetes urine-testing supplies	No charge up to a 100-day supply
Insulin-administration devices	\$10 up to a 100-day supply
These items described in the "Benefits" section under the heading "Outpatient drugs, supplies, and supplements"	
Generic	\$10 up to a 100-day supply (or 3 cycles for oral contraceptives)

<b>Drugs, supplies, and supplements</b>	<b>You Pay</b>
Brand name or compounded drugs	\$20 up to a 100-day supply (or 3 cycles for oral contraceptives)
Amino acid-modified products used to treat congenital errors of amino acid metabolism and elemental dietary enteral formula when used as a primary therapy for regional enteritis	No charge up to a 30-day supply
Emergency contraceptive pills	No charge
Drugs related to the treatment of sexual dysfunction disorders (episodic drugs are provided up to a maximum of 27 doses in any 100-day period)	50% Coinsurance up to a 100-day supply

**Limitation:** The day supply dispensed at the Copayment or Coinsurance may be reduced (a) to a 30-day supply maximum in any 30-day period for specific drugs (please call our Member Service Call Center for the current list of these drugs), or (b) if the pharmacy limits the amount dispensed because the drug is in limited supply in the market. Also, the Copayment or Coinsurance applies to each prescription as prescribed by a Plan Physician not to exceed a 100-day supply. Members must pay Charges for any quantities dispensed that exceed the applicable supply maximum.

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

<b>Durable medical equipment</b>	<b>You Pay</b>
Durable medical equipment used during a covered stay in a Plan Hospital or Skilled Nursing Facility	No charge
Durable medical equipment for use in the home and repair or replacement	20% Coinsurance
External sexual dysfunction devices	50% Coinsurance

<b>Family planning Services</b>	<b>You Pay</b>
Family planning Services	\$10 per visit

<b>Health education</b>	<b>You Pay</b>
Individual office visits	\$10 per visit
All other covered Services	No charge

<b>Hearing Services</b>	<b>You Pay</b>
Hearing tests	\$10 per visit

<b>Home health care</b>	<b>You Pay</b>
Home health care	No charge

<b>Hospice care</b>	<b>You Pay</b>
Hospice care	No charge

<b>Imaging, laboratory, and special procedures</b>	<b>You Pay</b>
Imaging, laboratory, special procedures, and ultraviolet light treatment visits	No charge

<b>Infertility Services</b>	<b>You Pay</b>
Office visits	\$10 per visit
Outpatient surgery	\$10 per procedure
Outpatient laboratory, imaging, and special procedures	No charge
Hospital inpatient care	No charge

<b>Mental health Services</b>	<b>You Pay</b>
Inpatient psychiatric care and hospital alternative Services	No charge

<b>Mental health Services</b>	<b>You Pay</b>
Outpatient visits:	
Individual therapy visits	\$10 per visit
Group therapy visits	\$5 per visit
<b>Ostomy and urological supplies</b>	<b>You Pay</b>
Ostomy and urological supplies	20% Coinsurance
<b>Prosthetic and orthotic devices</b>	<b>You Pay</b>
Internally implanted devices	No charge
External devices and enteral formula required for tube feeding	20% Coinsurance
<b>Reconstructive surgery</b>	<b>You Pay</b>
Inpatient care	No charge
Office visits	\$10 per visit
Outpatient surgery	\$10 per procedure
<b>Services associated with clinical trials</b>	<b>You Pay</b>
Covered care	The amounts you would pay if the Services were not provided in connection with a clinical trial
<b>Skilled nursing facility care</b>	<b>You Pay</b>
Care in a Skilled Nursing Facility	No charge
<b>Transplant Services</b>	<b>You Pay</b>
Inpatient care	No charge
Physician office visits	\$10 per visit
<b>Vision Services</b>	<b>You Pay</b>
Eye exams	\$10 per visit

### **Annual Out-of-Pocket Maximum**

There is a limit to the total amount of Copayments and Coinsurance you must pay under this *EOC* in a calendar year for the covered Services listed below. The limit is \$1,500 (for a Member) or \$3,000 (for an entire Family Unit). When you pay a Copayment or Coinsurance for these Services, ask for and keep the receipt. When the receipts add up to the annual out-of-pocket maximum, please call our Member Service Call Center to find out where to bring your receipts. When you bring them in, we will give you a document to show that you do not have to pay any more Copayments or Coinsurance for these Services through the end of the calendar year.

Only the Copayments and Coinsurance you pay for these Services apply toward the annual out-of-pocket maximum:

- Ambulance Services
- Amino acid-modified products used to treat congenital errors of amino acid metabolism
- Diabetic testing supplies and equipment and insulin-administration devices
- Emergency Department visits
- Home health care
- Hospice care
- Hospital care, including mental health inpatient care
- Imaging, laboratory, and special procedures
- Office visits (including professional Services such as dialysis treatment, health education, and physical, occupational, and speech therapy)
- Outpatient surgery
- Podiatric devices to prevent or treat diabetes-related complications

- Prostheses and lymphedema wraps needed after a Medically Necessary mastectomy
- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx

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