

\$20 Copayment Plan

HEALTH PLAN BENEFITS AND COVERAGE MATRIX

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

The Services described below are covered only if all the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary in the *Evidence of Coverage* for authorized referrals, Emergency Care, Post-stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

ANNUAL OUT-OF-POCKET MAXIMUM

For one Member	\$1,500 per calendar year
For an entire Family Unit of two or more Members	\$3,000 per calendar year

DEDUCTIBLE OR LIFETIME MAXIMUM

None

COORDINATION OF BENEFITS

Included

PROFESSIONAL SERVICES (PLAN PROVIDER OFFICE VISITS)

	YOU PAY
Primary and specialty care visits (includes routine and urgent care appointments)	\$20 per visit
Routine preventive physical exams	\$20 per visit
Well-child preventive care visits (0–24 months)	No charge
Family planning visits	\$20 per visit
Scheduled prenatal care and first postpartum visit	No charge
Voluntary termination of pregnancy	\$20 per procedure
Eye exams	\$20 per visit
Hearing tests	\$20 per visit
Physical, occupational, and speech therapy visits	\$20 per visit

OUTPATIENT SERVICES

	YOU PAY
Outpatient surgery	\$50 per procedure
Allergy injection visits	\$5 per visit
Allergy testing visits	\$20 per visit
Immunizations	No charge
X-rays and lab tests	\$10 per encounter (except that MRI, CT, & PET are \$50 per procedure)
Health education	\$20 per individual visit No charge for group visits

HOSPITALIZATION SERVICES

	YOU PAY
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	\$100 per day

EMERGENCY HEALTH COVERAGE

	YOU PAY
Emergency Department visits	\$100 per visit (does not apply if admitted directly to the hospital as an inpatient)

AMBULANCE SERVICES

	YOU PAY
Ambulance Services	\$75 per trip

PRESCRIPTION DRUG COVERAGE

Most covered outpatient items in accord with our drug formulary when obtained at Plan Pharmacies or through our mail order program (MOP):

Generic items obtained at a Plan Pharmacy

Refills obtained through MOP

Brand name items obtained at a Plan Pharmacy

Refills obtained through MOP

MOP: Many refills are available through our mail order program (MOP). Plan Pharmacies can give you details, including whether you can use the MOP to refill your prescription.

YOU PAY

\$10 for a 30-day supply or
\$30 for a 100-day supply
\$20 for a 100-day supply
\$30 for a 30-day supply or
\$90 for a 100-day supply
\$60 for a 100-day supply

DURABLE MEDICAL EQUIPMENT

Most covered durable medical equipment for home use in accord with our DME formulary up to a \$2,000 calendar year benefit limit as described in the *Evidence of Coverage*

YOU PAY

20% Coinsurance

MENTAL HEALTH SERVICES

Inpatient psychiatric care (up to 30 days per calendar year)

Outpatient visits:

Up to a total of 20 individual and group therapy visits per calendar year

Up to 20 additional group therapy visits that meet Medical Group criteria in the same calendar year

YOU PAY

\$100 per day
\$20 per individual therapy visit
\$10 per group therapy visit
\$10 per group therapy visit

Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.

CHEMICAL DEPENDENCY SERVICES

Inpatient detoxification

Outpatient individual therapy visits

Outpatient group therapy visits

Transitional residential recovery Services

(up to 60 days per calendar year, not to exceed 120 days in any five-year period)

YOU PAY

\$100 per day
\$20 per visit
\$5 per visit
\$100 per admission

HOME HEALTH SERVICES

Home health care (up to 100 two-hour visits per calendar year)

YOU PAY

No charge

OTHER

Skilled nursing facility care (up to 100 days per benefit period)

Hospice care

YOU PAY

No charge
No charge

This is a summary of the most frequently asked-about benefits and their Copayments and Coinsurance. This chart does not describe benefits. Please see the *Evidence of Coverage* for information about coverage, limitations, and exclusions for all benefits, including those not listed in this summary. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Introduction

WELCOME TO KAISER PERMANENTE

When you join Kaiser Permanente, you get a health plan that's dedicated to your total well-being.

Our preventive care programs and health education classes offer you and your family great ways to protect and improve your health. You get a wealth of information online with kaiserpermanente.org. Save time in requesting routine appointments and prescription refills. Use the extensive health and drug encyclopedias to learn more about your health. Find Plan Facilities and providers close to home or work.

When you need medical care, we've got you covered. You can have a personal physician who understands your lifestyle. You can often take care of many health needs at one place, in one trip—from office visits to lab work, pharmacy, and X-rays. Most of our facilities provide same-day urgent care appointments, and many have evening and weekend appointments. And, you're not limited to receiving care from just one facility; you pick the Plan Facility that's most convenient for you. If you need specialty care, you have access to a wide array of medical specialties. You can even self-refer to selected specialties. And you can depend on the security of emergency coverage anywhere in the world.

We are committed to investing first and foremost in your health. From routine checkups to online services to emergency care, you can count on us to help you stay healthy.

ABOUT THIS BOOKLET

This *Disclosure Form* summarizes some of the important features of your Kaiser Permanente membership, as well as general exclusions and limitations of your coverage.

Please read the following information so that you will know from whom or what group of providers you may obtain health care. Also, you should read this *Disclosure Form* and the *Evidence of Coverage* carefully if you have special health care needs.

Two Health Plan products. This *Disclosure Form* describes two Health Plan products (Traditional Plan and Deductible Plan). You may enroll in only one of these products. Everything in this *Disclosure Form* applies to both products except as otherwise indicated (including the *Health Plan Benefits and Coverage Matrix*).

Please see the *Health Plan Benefits and Coverage Matrix* for information about Copayments, Coinsurance, Deductibles, and benefits. If you have questions about benefits, please call our Member Service Call Center at **1-800-464-4000**.

Some capitalized terms have special meaning in this *Disclosure Form*, as described in the "Definitions" section at the end of this booklet.

Evidence of Coverage: To obtain an *Evidence of Coverage*, please contact your group benefits administrator to request one. Your *Evidence of Coverage* provides details about the terms and conditions of your coverage, including exclusions and limitations. Also, you have the right to review one before enrolling. This *Disclosure Form* is only a summary.

Note: State law requires disclosure form 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 at **1-800-464-4000**, 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.

How to obtain care

Our Members receive covered medical care from Plan Providers (physicians, registered nurses, nurse practitioners, and other medical professionals) at Plan Facilities except as described in this *Disclosure Form* or the *Evidence of Coverage* about:

- Getting a referral
- Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care
- Emergency ambulance Services

For Plan Facility locations, please refer to the enclosed facility listing, *Your Guidebook*, our Web site at kaiserpermanente.org, or your local telephone book under "Kaiser Permanente."

EMERGENCY CARE 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. Please call us at **1-800-225-8883** any time you are admitted to a non-Plan Hospital.

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 the enclosed facility listing or *Your Guidebook* for Plan Hospital Emergency Department locations in your area.

POST-STABILIZATION CARE. Post-stabilization Care is the Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable. We cover Post-stabilization Care 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** (or the notification telephone number on your ID card) *before* you receive the care if it is reasonably

possible to do so (otherwise, call us as soon as reasonably possible). Be sure to ask the non-Plan Provider to tell you what care (including any transportation) we have authorized since we do not cover unauthorized Post-stabilization Care or related transportation provided by non-Plan Providers.

Please refer to your *Evidence of Coverage* for coverage information, exclusions, and limitations.

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 have an urgent care need due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), we cover Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health if all of the following are true:

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

Please call us at **1-800-225-8883** any time you are admitted to a non-Plan Hospital.

YOUR IDENTIFICATION CARD

Each Member's Health Plan ID card has a medical record number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. 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.

If you need to get care before you receive your ID card, please ask your group benefits administrator for your group (purchaser) number and the date your coverage became effective. This information will be helpful if you need care before receiving your ID card.

Plan Facilities and Your Guidebook

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. For facility locations, please refer to the enclosed facility listing or call our Member Service Call Center at **1-800-464-4000**.

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

Plan Medical Offices and Plan Hospitals for your area are listed in *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. *Your Guidebook* also 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 preventive care guidelines and your Member rights and responsibilities.

Your Guidebook is subject to change and periodically updated. We will mail you *Your Guidebook* after you've enrolled. If you do not receive a copy or need another copy, call our Member Service Call Center at **1-800-464-4000** (TTY **1-800-777-1370**), weekdays 7 a.m. to 7 p.m. and weekends 7 a.m. to 3 p.m. You can also download a copy from our Web site at kaiserpermanente.org.

Your primary care Plan Physician

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

can select any available primary care Plan Physician from obstetrics/gynecology. You can change your primary care Plan Physician for any reason. To learn how to select a primary care Plan Physician, please call our Member Service Call Center at **1-800-464-4000**. You can find a directory of our Plan Physicians on our Web site at kaiserpermanente.org.

Getting a referral

REFERRALS TO PLAN PROVIDERS

Primary care Plan Physicians provide primary medical care, including pediatric care 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 medicine, pediatrics, optometry, psychiatry, and chemical dependency. Please check *Your Guidebook* to see if your facility has other departments that don't require a referral.

MEDICAL GROUP AUTHORIZATION PROCEDURE FOR CERTAIN REFERRALS

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

- **Services not available from Plan Providers.** If your Plan Physician decides that you require covered Services not available from Plan Providers, he or she will recommend to the Medical Group that you be referred to a non-Plan Provider inside or outside our Service Area. The appropriate Medical Group designee will authorize the Services if he or she determines that they are Medically Necessary and are not available from a Plan Provider. Referrals to non-Plan Physicians will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your Plan Physician what Services have been authorized
- **Bariatric surgery.** If your Plan Physician makes a written referral for bariatric surgery, the 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. The Medical Group's criteria for determining whether bariatric surgery is Medical Necessary are described in the Medical Group's bariatric surgery referral criteria, which are available upon request
- **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. If the DME request still doesn't appear to meet our DME formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our DME formulary, please refer to the *Evidence of Coverage*

- **Ostomy and urological supplies.** If your Plan Physician prescribes ostomy or urological supplies, he or she will submit a written referral to the Plan Hospital's designated coordinator, who will authorize the item if he or she determines that it is covered and the item is listed on our soft goods formulary for your condition. If the item doesn't appear to meet our soft goods formulary guidelines, then the coordinator will contact the Plan Physician for additional information. If the request still doesn't appear to meet our soft goods formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our soft goods formulary, please refer to the *Evidence of Coverage*
- **Transplants.** If your Plan Physician makes a written referral for a transplant, the Medical Group's regional transplant advisory committee or board (if one exists) will authorize the Services if it determines that they are Medically Necessary. In cases where no transplant committee or board exists, the Medical Group will refer you to physician(s) at a transplant center, and the Medical Group will authorize the Services if the transplant center's physician(s) determine that they are Medically Necessary. Note: A Plan Physician may provide or authorize a corneal transplant without using this Medical Group transplant authorization procedure

Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals. This description is only a brief summary of the authorization procedure. For more information and other Services that are subject to an authorization procedure, please refer to the *Evidence of Coverage* or call our Member Service Call Center at **1-800-464-4000**.

Second opinions

If you request a second opinion, it will be provided to you by an appropriately qualified medical professional. You can either ask your Plan Physician to help you arrange for a second medical opinion, or you can make an appointment with another Plan Physician. For more information, please refer to the *Evidence of Coverage*.

Provider reimbursement

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 at **1-800-464-4000**.

Your costs

COPAYMENTS AND COINSURANCE

Copayments or Coinsurance are due when you receive the Service. For items ordered in advance, you pay the Copayment or Coinsurance in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Copayment or Coinsurance before the item is ordered.

Note: If we bill you for a Copayment or Coinsurance, we will add a \$13.50 billing charge and send you a bill for the entire amount. This \$13.50 billing charge will not count toward the annual out-of-pocket maximum.

Copayments and Coinsurance are listed in the *Health Plan Benefits and Coverage Matrix*.

DEDUCTIBLES

If your coverage includes Deductibles, we will not cover certain Services at the Copayment or Coinsurance until you meet the applicable Deductible each calendar year. The only payments that count toward a Deductible are those you make for covered Services that are subject to the Deductible, but only if the Service would otherwise be covered. Please refer to the *Health Plan Benefits and Coverage Matrix* to learn if your coverage is subject to Deductibles and the amount of the Deductible(s). Please refer to your *Evidence of Coverage* for more information about Deductibles.

ANNUAL OUT-OF-POCKET MAXIMUM

There is a limit (specified in the *Health Plan Benefits and Coverage Matrix*) to the total amount you must pay for certain Services you receive in the same calendar year, which are listed in your *Evidence of Coverage*.

When you pay 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 at **1-800-464-4000** to find out where to turn in your receipts. When you turn them in, we will give you a document stating that you do not have to pay any more Copayments or Coinsurance for the specified Services through the end of the calendar year.

If your coverage includes Deductibles, when you pay an

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

PREPAYMENT OF 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).

YOUR LIABILITY FOR PAYMENT

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of noncovered Services you obtain from Plan Providers or non-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. In some cases, you may be eligible to receive Services from a terminated provider in accord with applicable law. Please refer to "Completion of Services from non-Plan Providers" in the "Miscellaneous notices" section for more information.

Reimbursement for Emergency Care, Post-stabilization Care, or Out-of-Area Urgent Care from a non-Plan Provider

If you receive Emergency Care, Post-stabilization Care, or Out-of-Area Urgent Care from a non-Plan Provider, 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, request our claim form by calling our Member Service Call Center 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 and receipts from the non-Plan Provider
- To request that a non-Plan Provider be paid for Services, you must send us our completed claim form and include any bills from the non-Plan Provider. If the non-Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the non-Plan Provider, please call our Member Service Call Center 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. For example, we may require documents such as travel documents or original travel tickets to validate your claim

Please refer to your *Evidence of Coverage* for additional instructions, coverage information, exclusions, limitations, and dispute resolution for denied claims.

Termination of benefits

Your group is required to inform the Subscriber of the date your membership terminates except as otherwise noted.

You will be billed as a non-Member for any Services you receive after your membership terminates.

Membership will cease for you (the Subscriber) and your Dependents if:

- The contract between your group and Kaiser Permanente is terminated for any reason
- You are no longer eligible for group coverage as described in your *Evidence of Coverage*
- 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, and you will not be allowed to enroll in Health Plan in the future:
 - ~ 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
- Your group fails to pay us the appropriate Dues for your Family Unit
- You fail to pay any amount you owe Health Plan or a Plan Provider (for example, if you fail to pay Copayments and Coinsurance). We will send written notice of the termination to the Subscriber at least 15 days before the termination date. Persons whose memberships are terminated for nonpayment of other charges who do not pay amounts due on or before the next scheduled payment due date may not enroll in Health Plan in the future

Please refer to the *Evidence of Coverage* for more information.

Continuation of membership

CONTINUATION OF GROUP COVERAGE

You may be able to continue your group coverage for a limited time after you would otherwise lose eligibility, if required by law under COBRA or Cal-COBRA. Please refer to the *Evidence of Coverage* for more information.

If you are called to active duty in the uniformed services, you may be able to continue your coverage for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. Please contact your group if you want to know how to elect USERRA coverage and how much you must pay your group.

CONVERTING TO AN INDIVIDUAL PLAN

You may be eligible to convert to our nongroup Individual-Conversion Plan if you no longer meet the eligibility requirements described in the *Evidence of Coverage*, or if you enroll in COBRA, Cal-COBRA, or USERRA continuation coverage and then lose eligibility for that coverage. You must apply for conversion of membership within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

For information about converting your membership or about other individual plans, please refer to the *Evidence of Coverage*, or call our Member Service Call Center at **1-800-464-4000**.

Getting assistance

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

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Call Center representatives are available to assist you, weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays), at **1-800-464-4000** (for the hearing and speech impaired, the TTY line is **1-800-777-1370**). For your convenience, you can also contact us through our Web site at **kaiserpermanente.org**.

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.

Dispute resolution and binding arbitration

Member Service representatives at our Plan Facilities or Member Service Call Center can help you with unresolved issues. They can also help you file a grievance orally or in writing. You can also submit a grievance electronically at **kaiserpermanente.org**.

Independent medical review is available if you believe that we improperly denied, modified, or delayed Services or payment of Services, and that either (1) our denial was based on a finding that the Services are not Medically Necessary, or (2) for life-threatening or seriously debilitating conditions, the requested treatment was denied as experimental or investigational. Also, if you should file a grievance and you later need help with it because your grievance is an emergency, it hasn't been resolved to your satisfaction, or it's unresolved after 30 days, you may call the California Department of Managed Health Care at **1-888-HMO-2219** for assistance.

Except for Small Claims Court cases and, if your group must comply with Employee Retirement Income Security Act (ERISA), certain benefit-related disputes, any dispute between Members, their heirs, or associated parties (on the one hand) and Health Plan, its health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising from your Health Plan membership, must be decided through binding arbitration. This includes claims for medical or hospital malpractice, for premises liability, or relating to the coverage for, or delivery of, Services, regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration.

This is a brief summary of dispute resolution options. Please refer to your *Evidence of Coverage* for more information, including the complete arbitration provision.

Renewal provisions

Your group is responsible for informing you when its contract with Kaiser Permanente is changed or terminated. The contract generally changes each year, or sooner if required by law.

Principal exclusions, limitations, and reductions of benefits

EXCLUSIONS

The following are the principal exclusions from coverage. See your *Evidence of Coverage* for the complete list, including details and any exceptions to the exclusions. Also, additional exclusions that apply only to a particular Service are listed in the description of that Service in the benefit description in your *Evidence of Coverage*.

- Care in a licensed intermediate care facility, except for covered hospice care
- Chiropractic Services
- Artificial insemination, unless otherwise stated in your *Evidence of Coverage*, and conception by artificial means
- Cosmetic Services, except for Services covered under "Reconstructive Surgery" and "Prosthetic and Orthotic Devices" in the *Evidence of Coverage*
- Custodial care, except for covered hospice care
- Dental care and dental X-rays
- Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, and Ace-type bandages
- Experimental or investigational Services, except as required by law for certain cancer clinical trials. You can request an independent medical review if you disagree with our decision to deny treatment because it is experimental or investigational (please refer to the *Evidence of Coverage* for details about independent medical review and other dispute resolution options)
- Eyeglasses, contact lenses, and contact lens eye examinations, unless otherwise stated in your *Evidence of Coverage*
- Services related to eye surgery or orthokeratologic Services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism
- Hearing aids, unless otherwise stated in your *Evidence of Coverage*
- Physical examinations related to employment, insurance, licensing, court orders, parole, or probation, unless a Plan Physician determines that the Services are Medically Necessary
- Routine foot care Services that are not Medically Necessary
- Services related to conception, pregnancy, or delivery in connection with a surrogacy arrangement, except for otherwise-covered Services provided to a Member who is a surrogate
- Services related to the diagnosis and treatment of infertility, unless otherwise stated in your *Evidence of Coverage*

- Services related to a noncovered Service, except for Services we would otherwise cover to treat complications of the noncovered Service
- Sexual reassignment surgery
- Speech therapy Services to treat social, behavioral, or cognitive delays in speech or language development, unless Medically Necessary
- Travel and lodging expenses
- Treatment of hair loss or growth

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,

such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes. Under these extreme circumstances, if you have an Emergency Medical Condition, go to the nearest hospital as described under "Emergency Care and Post-stabilization Care" in the "How to obtain care" section and we will provide coverage as described in that section.

REDUCTIONS

If you become ill or injured through the fault of a third party and you collect any money from the third party or from his or her insurance company, you must pay us Charges for any Services we covered for that injury or illness. Alternatively, we may file a subrogation claim on our own behalf against the third party. In addition to these third party liability claims by Kaiser Permanente, the contracts between Kaiser Permanente and some providers may allow these providers to collect all or a portion of the difference between Kaiser Permanente's Charges and the fees the provider charges to the general public for the Services you received.

Please refer to your *Evidence of Coverage* for additional information and other reductions (for example, surrogacy arrangements and workers' compensation).

To become a Member

We look forward to welcoming you as a Kaiser Permanente Member. If you are eligible to enroll, simply return a completed enrollment application to your group benefits administrator. Be sure to ask your benefits administrator for your group (purchaser) number and the date when your coverage becomes effective. You can begin using our Services on your effective date of coverage. Again, if you have any questions about Kaiser Permanente, please call our Member Service Call Center at **1-800-464-4000** or you can refer to the *Evidence of Coverage* for details about eligibility requirements.

Miscellaneous notices

COMPLETION OF SERVICES FROM NON-PLAN PROVIDERS

New Member. If you are currently receiving Services from a non-Plan Provider in one of the cases listed below under “Eligibility” and your enrollment with us will end your prior plan’s coverage of the provider’s Services, you may be eligible for limited coverage of that non-Plan Provider’s Services.

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

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

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends
- We may cover Services for serious chronic conditions until the earlier of (i) 12 months from your membership effective date if you are a new Member; (ii) 12 months from the termination date of the terminated provider; or (iii) the first day after a course of treatment is complete, when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and non-Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
 - ~ it persists without full cure
 - ~ it worsens over an extended period of time
 - ~ it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Care for children under age 3. We may cover completion of these Services until the earlier of (i) 12 months from the child’s membership effective date if the child is a new Member; (ii) 12 months from the termination date of the terminated provider; or (iii) the child’s third birthday

- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your membership effective date if you are a new Member or within 180 days of the termination date of the terminated provider

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

- Your Health Plan coverage is in effect on the date you receive the Service
- You are receiving Services in one of the cases listed above from a non-Plan Provider on your membership effective date if you are a new Member, or from the terminated Plan Provider on the provider’s termination date
- For new Members, when you enrolled in Health Plan, you did not have the option to continue with your previous health plan or to choose another plan (including an out-of-network option) that would cover the Services of your current non-Plan Provider
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside our Service Area
- The Services to be provided to you would be covered Services under your *Evidence of Coverage* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from your membership effective date if you are a new Member, or from the termination date of the Plan Provider

The Deductibles, Copayments, and Coinsurance for completion of Services are the same as those required for Services provided by a Plan Provider as described in the *Evidence of Coverage*. **For more information about this provision and to request the Services or a copy of our “Completion of Covered Services” policy, please call our Member Service Call Center.**

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 to request a copy of our drug formulary, please call our Member Service Call Center. Note: The presence of a drug on our drug formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition.

Our drug formulary guidelines allow you to obtain nonformulary prescription drugs (those not listed on our drug formulary for your condition) if they would otherwise be covered and a Plan Physician determines that they are Medically Necessary. If you disagree with your Plan Physician's determination that a nonformulary prescription drug is not Medically Necessary, you may file a grievance as described in the *Evidence of Coverage*. 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.

Please refer to the *Health Plan Benefits and Coverage Matrix* to learn if you have coverage for outpatient prescription drugs.

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.

NOT FEDERALLY QUALIFIED

This plan is not a federally qualified health benefit plan.

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 kaiserpermanente.org.

SPECIAL NOTE ABOUT MEDICARE

The information contained in this booklet is not applicable for most Medicare beneficiaries. Please check with your group benefits administrator to determine the correct *Disclosure Form* that applies to you if you are eligible for Medicare, and to learn whether you are eligible to enroll in Kaiser Permanente Senior Advantage.

Definitions

Allowance: A credit that you can use toward the purchase price of an item. If the price of the item(s) you select exceeds the allowance, you will pay the difference.

Charges: Charges means the following:

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

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. A summary of Copayments and Coinsurance is listed in the *Health Plan Benefits and Coverage Matrix*. For the complete list of Copayments and Coinsurance, please refer to your *Evidence of Coverage*.

Copayment: A specific dollar amount that you must pay when you receive a covered Service. A summary of Copayments and Coinsurance is listed in the *Health Plan Benefits and Coverage Matrix*. For the complete list of Copayments and Coinsurance, please refer to your *Evidence of Coverage*.

Deductible: The Deductible is an amount you must pay in a calendar year for certain Services before we will cover those Services at the Copayment or Coinsurance in that calendar year. Any Deductible amounts are listed in the *Health Plan Benefits and Coverage Matrix*.

Dependent: A Member who meets the eligibility requirements as a Dependent as described in the *Evidence of Coverage*.

Dues: Periodic membership charges paid by your 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) to determine whether you have an Emergency Medical Condition
- Medically Necessary Services required to make you Clinically Stable within the capabilities of the facility
- Emergency ambulance Services covered under "Ambulance Services" in the *Evidence of Coverage*

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 *Disclosure Form* sometimes refers to Health Plan as "we" or "us."

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

Medical Group: The Permanente Medical Group, Inc., a for-profit professional corporation.

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

Medicare: A federal health insurance program for people age 65 and older, certain disabled people, and those with end-stage renal disease (ESRD). In this *Disclosure Form*, Members who are "eligible for" Medicare Part A (or "eligible for" Medicare Part B) are those who would qualify for Medicare Part A (or Part B) coverage if they applied for it. Members who are "entitled to" Medicare Part A (or "entitled to" Medicare Part B) are those who have been granted Medicare Part A (or Part B) coverage.

Member: A person who is eligible and enrolled, and for whom we have received applicable Dues. This *Disclosure Form* 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 to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

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

Plan: Kaiser Permanente.

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

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

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

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

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

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

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

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. For information about Region locations in the District of Columbia and parts of Southern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington, please call our Member Service Call Center at **1-800-464-4000**.

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

- **Amador:** 95640, 95669
- **El Dorado:** 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762
- **Fresno:** 93242, 93602, 93606-07, 93609, 93611-13, 93616, 93618-19, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-22, 93724-29, 93740-41, 93744-45, 93747, 93750, 93755, 93760-62, 93764-65, 93771-80, 93784, 93786, 93790-94, 93844, 93888

- **Kings:** 93230, 93232, 93242, 93631, 93656
- **Madera:** 93601-02, 93604, 93614, 93623, 93626, 93637-39, 93643-45, 93653, 93669, 93720
- **Mariposa:** 93601, 93623, 93653
- **Napa:** 94503, 94508, 94515, 94558-59, 94562, 94567*, 94573-74, 94576, 94581, 94589-90, 94599, 95476
- **Placer:** 95602-04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95692, 95703, 95722, 95736, 95746-47, 95765
- **Santa Clara:** 94022-24, 94035, 94039-43, 94085-90, 94301-06, 94309-10, 94550, 95002, 95008-09, 95011, 95013-15, 95020-21, 95026, 95030-33, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95076, 95101-03, 95106, 95108-42, 95148, 95150-61, 95164, 95170-73, 95190-94, 95196
- **Sonoma:** 94515, 94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999, 95401-09, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, 95492
- **Sutter:** 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95837
- **Tulare:** 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- **Yolo:** 95605, 95607, 95612, 95616-18, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99
- **Yuba:** 95692, 95903, 95961

*Exception: Knoxville is not in our Service Area.

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

Services: Health care services or items.

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.