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Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation

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Cost Share Summary

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

Accumulation Period

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

Deductibles and Out-of-Pocket Maximums

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

If your Group's plan changes during an Accumulation Period, your deductibles and out-of-pocket maximums may increase or decrease, which may change the total amount you must accumulate to reach the deductibles or out-of-pocket maximums during that Accumulation Period.

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

Cost Share Summary Tables by Benefit

How to read the Cost Share summary tables

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

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

Administered drugs and products

Description of Administered Drugs and Products Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Whole blood, red blood cells, plasma, and platelets	No charge		✓
Allergy antigens (including administration)	$5 per visit		✓
Cancer chemotherapy drugs and adjuncts	No charge		✓
Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products (“biologics”) derived from tissue, cells, or blood	No charge		✓
Administered COVID-19 therapeutics from Plan Providers	No charge		✓
Administered COVID-19 therapeutics from Non-Plan Providers	50% Coinsurance		
All other administered drugs and products	No charge		✓
Drugs and products administered to you during a home visit	No charge		✓

Ambulance and non-emergency medical transportation (“NEMT”) services

Description of Ambulance and NEMT Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Ambulance services	No charge		✓
NEMT services	No charge		✓

Dialysis care

Description of Dialysis Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Equipment and supplies for home hemodialysis and home peritoneal dialysis	No charge		✓
One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment	No charge		✓
Hemodialysis and peritoneal dialysis treatment at a Plan Facility	$35 per visit		✓

Durable Medical Equipment ("DME") for home use

Description of DME Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Glucose monitors for diabetes blood testing and their supplies	No charge		✓
Peak flow meters	No charge		✓
Insulin pumps and supplies to operate the pump	No charge		✓
Other Base DME Items as described in this *EOC*	No charge		✓
Supplemental DME items as described in this *EOC*	No charge		
Retail-grade milk pumps	No charge		✓
Hospital-grade milk pumps	No charge		✓

Emergency Services and Care and Urgent Care

Description of Emergency Services and Care and Urgent Care	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency department visits	$100 per visit		✓
Urgent Care visits related to a Mental Health or Substance Use Disorder	$20 per visit		✓
Urgent Care related to a Mental Health or Substance Use Disorder program	No charge		✓
All other Urgent Care visits	$20 per visit		✓

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

Fertility Services (pending regulatory approval)

Description of Fertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Office visits	$20 per visit		✓

Description of Fertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Specialty Care Office visits	$35 per visit		✓
Outpatient surgery and outpatient procedures, including retrieval and procurement (see "Fertility Services" in the "Benefits" section for benefit limits): • In any setting when licensed staff monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort • In an outpatient surgery area (an outpatient or ambulatory surgery center or same day surgery in a hospital operating room) whether or not the surgery or procedure requires a licensed staff member to monitor your vital signs as described above	$100 per procedure		✓
Any other outpatient surgery or outpatient procedure in a medical office exam room that does not require a licensed staff member to monitor your vital signs as described above	$35 per procedure		✓
Storage of reproductive materials	No charge		✓
Outpatient imaging	No charge		✓
Outpatient laboratory	No charge		✓
Hospital inpatient services (including room and board, drugs, imaging, laboratory, other diagnostic and treatment services, and Plan Physician services)	$250 per admission		✓

Health education

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

Description of Health Education Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Covered health education materials	No charge		✓

Hearing services

Description of Hearing Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hearing exams with an audiologist to determine the need for hearing correction	$20 per visit		✓
Physician Specialist Visits to diagnose and treat hearing problems	$35 per visit		✓
Hearing aids, including, fitting, counseling, adjustment, cleaning, and inspection	Not covered		

Home health care

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

Hospice care

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

Hospital inpatient services

Description of Hospital Inpatient Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospital inpatient stays	$250 per admission		✓

Injury to teeth

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

Mental health services

Description of Mental Health Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient mental health hospital stays	$250 per admission		✓
Individual mental health evaluation and treatment	$20 per visit		✓
Group mental health treatment	$10 per visit		✓
Partial hospitalization	No charge		✓
Other intensive psychiatric treatment programs	No charge		✓
Residential mental health treatment services	No charge		✓
Behavioral Health Treatment for Autism Spectrum Disorder	No charge		✓
Electroconvulsive therapy	$20 per visit		✓
Transcranial magnetic stimulation	$20 per visit		✓

Office visits

Description of Office Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this “Cost Share Summary”	$20 per visit		✓
Physician Specialist Visits that are not described elsewhere in this “Cost Share Summary”	$35 per visit		✓
Group appointments that are not described elsewhere in this “Cost Share Summary”	$10 per visit		✓
Acupuncture services	$20 per visit		✓

Ostomy and urological supplies

Description of Ostomy and Urological Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Ostomy and urological supplies as described in this *EOC*	No charge		✓

Outpatient imaging, laboratory, and other diagnostic and treatment services

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans	No charge		✓
Basic imaging services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds	No charge		✓
Nuclear medicine	No charge		✓
Routine retinal photography screenings	No charge		✓
Routine laboratory tests to monitor the effectiveness of dialysis	No charge		✓
Over-the-counter COVID-19 tests obtained from Plan Providers as described in this *EOC* (up to a total of 8 tests from Plan Providers and Non-Plan Providers per calendar month), not including combination COVID-19/influenza tests	No charge		✓
Over-the-counter COVID-19 tests obtained from Non-Plan Providers as described in this *EOC* (up to a total of 8 tests from Plan Providers and Non-Plan Providers per calendar month, not to exceed $12 per test, including all fees and taxes, if you obtain the test from a Non-Plan Provider)	50% Coinsurance		
Laboratory tests to diagnose or screen for COVID-19 obtained from Plan Providers	No charge		✓
Laboratory tests to diagnose or screen for COVID-19 obtained from Non-Plan Providers (except for providers of Emergency Services and Care or Out-of-Area Urgent Care)	50% Coinsurance		
All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available)	No charge		✓
Diagnostic services provided by Plan Providers who are not physicians (such as EKGs and EEGs)	No charge		✓
Radiation therapy	No charge		✓
Ultraviolet light treatments (including ultraviolet light therapy equipment as described in this *EOC*)	No charge		✓

Outpatient pharmacy services

If the "Cost Share at a Plan Pharmacy" column in this section provides Cost Share for a 30-day supply and your Plan Physician prescribes more than this, you may be able to obtain more than a 30-day supply at one time up to the day supply limit for that drug. Applicable Cost Share will apply. For example, two 30-day copayments may be due when picking up a 60-day prescription, three copayments may be due when picking up a 100-day prescription at the pharmacy.

Most items

Description of Most Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on Tier 1 not described elsewhere in this "Cost Share Summary"	$10 for up to a 30-day supply	$20 for up to a 100-day supply		✓
Items on Tier 2 not described elsewhere in this "Cost Share Summary"	$30 for up to a 30-day supply	$60 for up to a 100-day supply		✓
Items on Tier 4 not described elsewhere in this "Cost Share Summary"	$30 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Base drugs, supplies, and supplements

Description of Base Drugs, Supplies and Supplements	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Hematopoietic agents for dialysis	No charge for up to a 30-day supply	Not available		✓
Elemental dietary enteral formula when used as a primary therapy for regional enteritis	No charge for up to a 30-day supply	Not available		✓
All other items on Tier 1 as described in this *EOC*	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
All other items on Tier 2 as described in this *EOC*	$30 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
All other items on Tier 4 as described in this *EOC*	$30 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Anticancer drugs and certain critical adjuncts following a diagnosis of cancer

Description of Anticancer Drugs and Certain Critical Adjuncts	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Oral anticancer drugs on Tier 1	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on Tier 2	$30 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on Tier 4	$30 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on Tier 1	$10 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on Tier 2	$30 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on Tier 4	$30 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Home infusion drugs

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

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

Certain state-mandated items

Description of Certain State-Mandated Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)	No charge for up to a 30-day supply	Not available		✓
Therapeutics for COVID-19 obtained from Plan Providers	No charge for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Therapeutics for COVID-19 obtained from Non-Plan Providers (except for providers of Emergency Services and Care or Out-of-Area Urgent Care)	50% Coinsurance for up to a 30-day supply	Not available		
Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing	No charge for up to a 100-day supply	Not available		✓
Insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear)	$10 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Human milk as described in this *EOC*	No charge	Not available		✓

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

Contraceptive drugs and devices

Description of Contraceptive Drugs and Devices	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
The following hormonal contraceptive items on Tier 1: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Availability for mail order varies by item. Talk to your local pharmacy		✓

Description of Contraceptive Drugs and Devices	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
The following contraceptive items on Tier 1: • Spermicide • Sponges • Contraceptive gel	No charge for up to a 100-day supply	Not available		✓
The following hormonal contraceptive items on Tier 2: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Availability for mail order varies by item. Talk to your local pharmacy		✓
The following contraceptive items on Tier 2: • Spermicide • Sponges • Contraceptive gel	No charge for up to a 100-day supply	Not available		✓
Emergency contraception	No charge	Not available		✓
Diaphragms, cervical caps, and up to a 30-day supply of condoms	No charge	Not available		✓

Certain preventive items

Description of Certain Preventive Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on our Preventive Services list on our website at **kp.org/prevention** when prescribed by a Plan Provider	No charge for up to a 100-day supply	Not available		✓
Insulin on Tier 1	$10 for up to a 30-day supply	$20 for up to a 100-day supply		✓
Insulin on Tier 2	$30 for up to a 30-day supply	$60 for up to a 100-day supply		✓

Fertility and sexual dysfunction drugs (pending regulatory approval)

Description of Fertility and Sexual Dysfunction Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Prescription Drugs on Tier 1 prescribed in connection with covered Fertility Services	$10 for up to a 30-day supply	$20 for up to a 100-day supply		✓
Prescription Drugs on Tier 2 prescribed in connection with covered Fertility Services	$30 for up to a 30-day supply	$60 for up to a 100-day supply		✓
Prescription Drugs on Tier 4 prescribed in connection with covered Fertility Services	$30 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Prescription Drugs on Tier 1 prescribed for sexual dysfunction disorders	50% Coinsurance (not to exceed $50) for up to a 100-day supply	50% Coinsurance (not to exceed $50) for up to a 100-day supply		✓
Prescription Drugs on Tier 2 and Tier 4 prescribed for sexual dysfunction disorders	50% Coinsurance (not to exceed $100) for up to a 100-day supply	50% Coinsurance (not to exceed $100) for up to a 100-day supply		✓

Weight loss drugs

Description of Weight Loss Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Prescription Drugs on Tier 1 prescribed solely for the purpose of losing weight except when medically necessary to treat Class III or severe obesity	Not covered			
Prescription Drugs on Tier 2 prescribed solely for the purpose of losing weight except when medically necessary to treat Class III or severe obesity	Not covered			
Prescription Drugs on Tier 4 prescribed solely for the purpose of losing weight except when medically necessary to treat Class III or severe obesity	Not covered			

For Prescription Drugs related to the treatment of Class III or severe obesity, refer to the “Most items” table above.

Outpatient surgery and outpatient procedures

Description of Outpatient Surgery and Outpatient Procedure Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient surgery and outpatient procedures: • In any setting when licensed staff monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort • In an outpatient surgery area (an outpatient or ambulatory surgery center or same day surgery in a hospital operating room) whether or not the surgery or procedure requires a licensed staff member to monitor your vital signs as described above	$100 per procedure		✓
Any other outpatient surgery or outpatient procedure in a medical office exam room that does not require a licensed staff member to monitor your vital signs as described above	$35 per procedure		✓

Preventive Services

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine physical exams, including well-woman, postpartum follow-up, and preventive exams for Members age 2 and older	No charge		✓
Well-child preventive exams for Members (up to and including 23 months)	No charge		✓
Normal series of regularly scheduled preventive prenatal care exams after confirmation of pregnancy	No charge		✓
Immunizations (including the vaccine) administered to you in a Plan Medical Office	No charge		✓
Immunizations (including the vaccine) for COVID-19 administered by Non-Plan Providers (except for providers of Emergency Services and Care or Out-of-Area Urgent Care)	50% Coinsurance		
Tuberculosis skin tests	No charge		✓
Screening and counseling services when provided during a routine physical exam or a well-child preventive exam, such as obesity counseling, routine vision and hearing screenings, alcohol and substance abuse screenings, health education, depression screening, and developmental screenings to diagnose and assess potential developmental delays	No charge		✓

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Screening colonoscopies	No charge		✓
Screening flexible sigmoidoscopies	No charge		✓
Routine imaging screenings such as mammograms	No charge		✓
Bone density CT scans	No charge		✓
Bone density DEXA scans	No charge		✓
Routine laboratory tests and screenings, such as cancer screening tests, sexually transmitted infection ("STI") tests, cholesterol screening tests, and glucose tolerance tests	No charge		✓
Other laboratory screening tests, such as fecal occult blood tests and hepatitis B screening tests	No charge		✓

Prosthetic and orthotic devices

Description of Prosthetic and Orthotic Device Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
External prosthetic and orthotic devices as described in this *EOC*	No charge		✓
Supplemental prosthetic and orthotic devices as described in this *EOC*	No charge		✓

Rehabilitative and habilitative services

Description of Rehabilitative and Habilitative Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Individual outpatient physical, occupational, and speech therapy	$20 per visit		✓
Group outpatient physical, occupational, and speech therapy	$10 per visit		✓
Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program	$20 per day		✓

Reproductive health services

Family planning services

Description of Family Planning Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Family planning counseling	No charge		✓
Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices (“IUDs”) and office visits related to their insertion, removal, and management when provided to prevent pregnancy	No charge		✓
Sterilization procedures for Members assigned female at birth if performed in an outpatient or ambulatory surgery center or in a hospital operating room	No charge		✓
All other sterilization procedures for Members assigned female at birth	No charge		✓
Sterilization procedures for Members assigned male at birth if performed in an outpatient or ambulatory surgery center or in a hospital operating room	No charge		✓
All other sterilization procedures for Members assigned male at birth	No charge		✓

Abortion and abortion-related services

Description of Abortion and Abortion-Related Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Surgical abortion	No charge		✓
Outpatient Prescription Drugs, in accord with our drug formulary guidelines	No charge for up to a 100-day supply		✓
Other abortion-related services	No charge		✓

Plan Doula services

Description of Plan Doula Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Initial, prenatal, or postpartum visits	No charge		✓
Support during labor and delivery	No charge		✓

Skilled nursing facility care

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

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

Substance use disorder treatment

Description of Substance Use Disorder Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient detoxification	$250 per admission		✓
Individual substance use disorder evaluation and treatment	$20 per visit		✓
Group substance use disorder treatment	$5 per visit		✓
Intensive outpatient and day-treatment programs	No charge		✓
Methadone maintenance treatment	No charge		✓
Residential substance use disorder treatment	$100 per admission		✓

Telehealth visits

Interactive video visits

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

Scheduled telephone visits

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

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

Vision services for Adult Members

Description of Vision Services for Adult Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$35 per visit		✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$20 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Low vision devices (including fitting and dispensing)	Not covered		

Vision services for Pediatric Members

Description of Vision Services for Pediatric Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$35 per visit		✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$20 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓

Description of Vision Services for Pediatric Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Low vision devices (including fitting and dispensing)	Not covered		

CARE Plan

The California Community Assistance, Recovery, and Empowerment ("CARE") Act established a system for individuals with severe mental illness to be evaluated and given a treatment plan developed by a county behavioral health agency ("CARE Plan"). If a Member has a court-approved CARE Plan, we cover the services required under that plan when provided by Plan Providers or Non-Plan Providers at **no charge**, with the exception of Prescription Drugs. Prescription Drugs required under a court-approved CARE Plan are subject to the same Cost Share as Prescription Drugs prescribed by Plan Providers, as described in this Cost Share Summary, and are also subject to prior authorization by Health Plan. To inform us that you have a court-approved CARE Plan, call Member Services.

Health Care Treatment Following Rape or Sexual Assault

As required by state law, for a period of nine months after a Member initiates treatment after a rape or sexual assault, Cost Share for the following services is **no charge**:

- Emergency Services and Care related to the rape or sexual assault that are received from Plan Providers or Non-Plan Providers
- Related follow-up services that are received from Plan Providers, including but not limited to the following:
  - Mental health services
  - Prescription Drugs, in accord with our drug formulary guidelines
  - Substance use disorder treatment services

Introduction

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

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

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

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

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

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

About Kaiser Permanente

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

Our medical care program

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

We provide Covered Benefits to Members using Plan Providers located in your Service Area. You must receive all Covered Benefits from Plan Providers inside your Service Area, except as described in the sections listed below for the following services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Covered Benefits" section
- Covered Benefits received outside of your Service Area as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Covered Benefits" section
- COVID-19 services as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Pharmacy Services," and "Preventive Services" in the "Covered Benefits" section
- Emergency ambulance services as described under "Ambulance Services" in the "Covered Benefits" section
- Emergency Services and Care, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "How to Obtain Covered Benefits" section
- Hospice care as described under "Hospice Care" in the "Covered Benefits" section

Your Service Area

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), which we call your "Home Region." **The coverage information in this *EOC* applies when you obtain care in the Service Area of your Home Region.** See "Home Region" in the "Definitions" section for the geographic area of your Service Area. When you visit the other California Region, you may receive care as described in "Receiving Care Outside of Your Home Region" in the "How to Obtain Covered Benefits" section.

Term of this *EOC*

This *EOC* is for the period January 1, 2027, through December 31, 2027, unless amended. Your Group can

tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended.

Definitions

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

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

Advance Health Care Directive: A legal document that tells your doctor, family, and friends about the health care you want if you can no longer make decisions for yourself. It explains the types of special treatment you want or do not want. For more information, contact the Plan or the California Attorney General's Office.

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

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

Appropriately Qualified Health Care Provider: A Health Care Provider who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

Approved Clinical Trial: A phase I, phase II, phase III, or phase IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or another Life-Threatening disease or condition that meets at least one of the following:

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
  - The National Institutes of Health
  - The federal Centers for Disease Control and Prevention
  - The Agency for Healthcare Research and Quality
  - The federal Centers for Medicare and Medicaid Services
  - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs
  - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
  - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
    - The United States Department of Veterans Affairs
    - The United States Department of Defense
    - The United States Department of Energy
- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration

Assisted Reproduction Agreement (pending regulatory approval): A written agreement in accord with California Family Code Section 7962 between a person (Intended Parent) who intends to be the legal parent of a child born through assisted reproduction and a third party. The agreement defines the terms of the relationship between the parties. For the purposes of this *EOC*, "Assisted Reproduction Agreement" includes, but is not limited to: donor arrangements, surrogacy arrangements, and Gestational Carrier arrangements.

Behavioral Health Treatment for Autism Spectrum Disorder: Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of a person with autism spectrum disorder (or treat mental

health conditions other than autism spectrum disorder when this treatment is clinically indicated) that meet the following criteria:

- The treatment is prescribed by a Plan Physician, or is developed by a Plan Provider who is a psychologist
- The treatment is administered by a Plan Provider who is a qualified autism service provider, qualified autism service professional, or qualified autism service paraprofessional, as defined in California Business and Professions Code sections 4999.200-4999.202

Charges: "Charges" means the following:

- For services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for services provided to Members
- For services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For air ambulance services received from Non-Plan Providers when you have an Emergency Medical Condition or Psychiatric Emergency Medical Condition, the amount required to be paid by Health Plan pursuant to federal law
- For other Emergency Services and Care received from Non-Plan Providers (including Post-Stabilization Care that constitutes Emergency Services and Care under federal law), the amount required to be paid by Health Plan pursuant to state law, when it is applicable, or federal law
- For all other services received from Non-Plan Providers (including Post-Stabilization services that are not Emergency Services and Care under federal law), the amount (1) required to be paid pursuant to state law, when it is applicable, or federal law, or (2) in the event that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the Non-Plan Provider and Health Plan or, absent such an agreement, the usual, customary and reasonable rate for those services as determined by Health Plan based on objective criteria
- For all other services, the payments that Kaiser Permanente makes for the services or, if Kaiser Permanente subtracts your Cost Share from its payment, the amount Kaiser Permanente would have paid if it did not subtract your Cost Share

Cigna Healthcare PPO Network: The Cigna Healthcare PPO Network refers to the health care providers (doctors, hospitals, specialists) contracted as part of a shared administration network arrangement called Cigna Healthcare PPO for Shared Administration.

Cigna Healthcare is an independent company and not affiliated with Kaiser Foundation Health Plan, Inc., and its subsidiary health plans. Access to the Cigna Healthcare PPO Network is available through Cigna Healthcare's contractual relationship with the Kaiser Permanente health plans. The Cigna Healthcare PPO Network is provided exclusively by or through operating subsidiaries of The Cigna Group, including Cigna Health and Life Insurance Company. The Cigna Healthcare name, logo, and other marks are owned by Cigna Intellectual Property, Inc.

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

Copayment: A specific dollar amount that you must pay when you receive a covered Service under this *EOC*. Note: The dollar amount of the Copayment can be $0 (no charge).

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

Covered Benefits: Those Medically Necessary services and supplies that you are entitled to receive under an individual plan or group agreement and which are described in this *EOC* or under California health plan law.

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

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

Drug Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain items covered under "Outpatient Pharmacy Services" in the "Covered Benefits" section before we will cover those services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to the "Cost Share Summary" section to learn whether your coverage includes a Drug Deductible, the services that are subject to the Drug Deductible, and the Drug Deductible amount.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

- Placing the patient's health in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency Services and Care: Either or both of the following:

- Medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician and surgeon, to determine if an Emergency Medical Condition or active labor exists and, if it does, the care, treatment, and surgery, within the scope of that person's license, if necessary to relieve or eliminate the Emergency Medical Condition, within the capability of the facility
- An additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a Psychiatric Emergency Medical Condition exists, and the care and treatment necessary to relieve or eliminate the Psychiatric Emergency Medical Condition within the capability of the facility

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

Evidence of Coverage: Any certificate, agreement, contract, brochure, or letter of entitlement issued to a Member setting forth the coverage to which the Member is entitled.

Experimental Services: Drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

Family: A Subscriber and all of their Dependents.

Fertility Services (pending regulatory approval): Services to help a covered Member become a parent.

Gestational Carrier (pending regulatory approval): A third party who is not an Intended Parent and who agrees to carry a pregnancy on behalf of the Intended Parent(s) pursuant to an Assisted Reproduction Agreement.

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

Health Care Provider: Any professional person, medical group, independent practice association, organization, health care facility, or other person or institution licensed or authorized by the state to deliver or furnish health care services.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. Health Plan is a health care service plan licensed to offer health care coverage by the Department of Managed Health Care.

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region). Note: We may expand the Service Area of your Home Region at any time by giving written notice to your Group. ZIP codes are subject to change by the U.S. Postal Service.

The ZIP codes below for each county are in the Service Area of your Home Region:

- Alameda County (whole county): 94501-02, 94505, 94514, 94536-46, 94550-52, 94555, 94557, 94560, 94566, 94568, 94577-80, 94586-88, 94601-15, 94617-21, 94622-24, 94649, 94659-62, 94666, 94701-10, 94712, 94720, 95377, 95391
- Amador County: 95640, 95669
- Contra Costa County (whole county): 94505-07, 94509, 94511, 94513-14, 94516-31, 94547-49, 94551, 94553, 94556, 94561, 94563-65, 94569-70, 94572, 94575, 94582-83, 94595-98, 94706-08, 94801-08, 94820, 94850
- El Dorado County: 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762
- Fresno County: 93242, 93602, 93606-07, 93609, 93611-13, 93616, 93618-19, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-30, 93737, 93740-41, 93744-45, 93747, 93750, 93755, 93760-61, 93764-65, 93771-79, 93786, 93790-94, 93844, 93888
- Kings County: 93230, 93232, 93242, 93631, 93656
- Madera County: 93601-02, 93604, 93614, 93623, 93626, 93636-39, 93643-45, 93653, 93669, 93720

- Marin County (whole county): 94901, 94903-04, 94912-15, 94920, 94924-25, 94929-30, 94933, 94937-42, 94945-50, 94952, 94956-57, 94960, 94963-66, 94970-71, 94973-74, 94976-79
- Mariposa County: 93601, 93623, 93653
- Monterey County: 93901, 93902, 93905, 93906, 93907, 93912, 93915, 93933, 93955, 93962, 95004, 95012, 95039, 95076
- Napa County (whole county): 94503, 94508, 94515, 94558-59, 94562, 94567, 94573-74, 94576, 94581, 94599, 95476
- Placer County: 95602-04, 95610, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95703, 95722, 95736, 95746-47, 95765
- Sacramento County (whole county): 94203-06, 94209, 94229-30, 94232, 94235-37, 94239-40, 94244, 94247-50, 94252, 94254, 94256-59, 94261-63, 94267-69, 94271, 94273-74, 94277-80, 94283-85, 94287-90, 94293-98, 94571, 95608-11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638-39, 95641, 95652, 95655, 95660, 95662, 95670-71, 95673, 95678, 95680, 95683, 95690, 95693, 95741-42, 95757-59, 95763, 95811-38, 95840-43, 95851-53, 95860, 95864-67, 95894, 95899
- San Francisco County (whole county): 94102-05, 94107-12, 94114-34, 94137, 94139-47, 94151, 94158-61, 94163-64, 94172, 94177, 94188
- San Joaquin County (whole county): 94514, 95201-13, 95215, 95219-20, 95227, 95230-31, 95234, 95236-37, 95240-42, 95253, 95258, 95267, 95269, 95296-97, 95304, 95320, 95330, 95336-37, 95361, 95366, 95376-78, 95385, 95391, 95632, 95686, 95690
- San Mateo County (whole county): 94002, 94005, 94010-11, 94014-21, 94025-28, 94030, 94037-38, 94044, 94060-66, 94070, 94074, 94080, 94083, 94128, 94303, 94401-04, 94497
- Santa Clara County: 94022-24, 94035, 94039-43, 94085-89, 94301-06, 94309, 94550, 95002, 95008-09, 95011, 95013-15, 95020-21, 95026, 95030-33, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95076, 95101, 95103, 95106, 95108-13, 95115-36, 95138-41, 95148, 95150-61, 95164, 95170, 95172-73, 95190-94, 95196
- Santa Cruz County (whole county): 95001, 95003, 95005-7, 95010, 95017-19, 95033, 95041, 95060-67, 95073, 95076-77
- Solano County (whole county): 94503, 94510, 94512, 94533-35, 94571, 94585, 94589-92, 95616, 95618, 95620, 95625, 95687-88, 95690, 95694, 95696
- Sonoma County: 94515, 94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999, 95401-07, 95409, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, 95492
- Stanislaus County (whole county): 95230, 95304, 95307, 95313, 95316, 95319, 95322-23, 95326, 95328-29, 95350-58, 95360-61, 95363, 95367-68, 95380-82, 95385-87, 95397
- Sutter County: 95626, 95645, 95659, 95668, 95674, 95676, 95692, 95836-7
- Tulare County: 93618, 93631, 93646, 93654, 93666, 93673
- Yolo County: 95605, 95607, 95612, 95615-18, 95620, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99
- Yuba County: 95692, 95903, 95961

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

If you have a question about whether a ZIP code is in your Service Area, call Member Services.

Independent Medical Review ("IMR"): A review of your health plans denial, modification, or delay of your request for health care services or treatment. The review is provided by the Department of Managed Health Care and conducted by independent medical experts. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by your health plan related to 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. Your health plan must pay for the services if an IMR decides you need it.

Infertility: A condition or status characterized by any of the following:

- A Plan Physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition does not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility in the third bullet

- A person's inability to reproduce either as an individual or with their partner without medical intervention
- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this section, "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility

Intended Parent (pending regulatory approval): A Member with an Infertility diagnosis who intends to become a legal parent of a child resulting from services covered under the "Fertility Services" section.

Investigational Services: Those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

- Testing is not complete; and
- The efficacy and safety of such services in human subjects are not yet established; and
- The service is not in wide usage

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

Kaiser Permanente State: California, Colorado, District of Columbia, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington.

Life-Threatening: Either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival

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

Medically Necessary: A service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of care, including generally accepted standards of Mental Health or Substance Use Disorder care
- Clinically appropriate in terms of type, frequency, extent, site, and duration
- Not primarily for the economic benefit of the health care service plan and Members or for the convenience of the patient, treating physician, or other Health Care Provider

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

Member: A Subscriber or Dependent of a Subscriber, who has enrolled in this Kaiser Permanente Traditional HMO Plan, and whose coverage is active.

Mental Health or Substance Use Disorder: A mental health condition or substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that is listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

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

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

Non–Plan Pharmacy: A pharmacy other than a Plan Pharmacy.

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

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

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

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

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

Outpatient Prescription Drug: A self-administered drug that is approved by the federal Food and Drug Administration for sale to the public through a retail or mail order pharmacy, requires a prescription, and has not been provided for use on an inpatient basis.

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

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

Plan Doula: Any Plan Doula that is listed in the Doula Services directory on our website at **kp.org/doulacare**. The directory is updated periodically. The availability of Plan Doulas may change. If you have questions, call Member Services.

Plan Facility: Any facility specifically identified in the Provider Directory on our website at **kp.org/facilities** as owned by Kaiser Permanente or as Kaiser Permanente Affiliated. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, call Member Services.

Plan Hospital: Any hospital specifically identified in the Provider Directory on our website at **kp.org/facilities** as owned by Kaiser Permanente or as Kaiser Permanente Affiliated. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, call Member Services.

Plan Medical Office: Any medical office specifically identified in the Provider Directory on our website at **kp.org/facilities** as owned by Kaiser Permanente or as Kaiser Permanente Affiliated. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The directory is updated periodically. The availability of Plan Medical Offices may change. If you have questions, call Member Services.

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

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for certain Covered Benefits that you receive in the same Accumulation Period. Refer to the "Cost Share Summary" section to find your Plan Out-of-Pocket Maximum amount and to learn which services apply to the Plan Out-of-Pocket Maximum.

Plan Pharmacy: Any pharmacy specifically identified in the Provider Directory on our website at **kp.org/facilities** as owned by Kaiser Permanente or as Kaiser Permanente Affiliated. The directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, call Member Services.

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

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

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

Post-Stabilization Care: Medically Necessary services related to your Emergency Medical Condition or Psychiatric Emergency Medical Condition that you receive in a hospital (including the emergency department), an independent freestanding emergency department, or a skilled nursing facility after your treating physician determines that this condition is Stabilized. Post-Stabilization Care also includes durable medical equipment covered under this *EOC*, if it is Medically Necessary after discharge from an emergency department and related to the same Emergency Medical Condition. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Covered Benefits" section.

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

Prescription Drug: A drug approved by the federal Food and Drug Administration ("FDA") for sale to consumers that requires a prescription and is not

provided for use on an inpatient basis. The term "drug" or "prescription drug" includes the following:

- Disposable devices that are medically necessary for the administration of a covered prescription drug, such as spacers and inhalers for the administration of aerosol outpatient prescription drugs
- Syringes for self-injectable prescription drugs that are not dispensed in pre-filled syringes
- Drugs, devices, and FDA-approved products covered under the prescription drug benefit of the product pursuant to sections 1367.002, 1367.25, and 1367.51 of the Health and Safety Code, including any such over-the-counter drugs, devices, and FDA-approved products
- Any vaccines or other health care benefits covered under "Outpatient Pharmacy Services" in the *EOC* for this Kaiser Permanente Traditional HMO Plan

Preventive Services: Covered Benefits listed on our website at **kp.org/prevention** that prevent or detect illness and do one or more of the following:

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

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

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

Provider Directory: A directory of physicians, licensed health care professionals, and facilities in your Service Area. This directory is available on our website at **kp.org/facilities**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, call Member Services.

Psychiatric Emergency Medical Condition: A mental disorder that manifests itself by acute symptoms of sufficient severity that renders the patient as being either: an immediate danger to himself or herself or to others, or immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

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

Seriously Debilitating: Diseases or conditions that cause major irreversible morbidity.

Service Area: The geographic area designated by the plan within which a plan shall provide health care services.

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

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

Stabilize: To provide the medical treatment of the Emergency Medical Condition or Psychiatric Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant person who is having contractions, when there is inadequate time to safely transfer them to another hospital before delivery (or the transfer may pose a threat to the health or safety of the pregnant person or unborn child), "Stabilize" means to deliver (including the placenta).

Standard Fertility Preservation Services: Procedures that are consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine.

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

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

Trans-Inclusive Health Care: Comprehensive health care that is consistent with the standards of care for individuals who identify as transgender, gender diverse, or intersex; honors an individual's personal bodily autonomy; does not make assumptions about an individual's gender; accepts gender fluidity and nontraditional gender presentation; and treats everyone with compassion, understanding, and respect.

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

Premiums, Eligibility, and Enrollment

Premiums

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

Who Is Eligible

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

Group eligibility requirements

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

Service Area eligibility requirements

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

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

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

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

For more information about the Service Areas of the other Regions, call Member Services.

Eligibility as a Subscriber

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

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

Eligibility as a Dependent

Enrolling a Dependent

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

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

If you have a baby

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

Age limit of Dependent children

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

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

Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption or foster care) who reach the age limit may continue coverage under this *EOC* if all of the following conditions are met:

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

Overage Dependent certification

Proof may be required for a Dependent to be eligible to continue coverage as an overage Dependent. If we request it, the Subscriber must provide us documentation of the dependent's incapacity and dependency as follows:

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

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

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

If the Subscriber is enrolled under a Kaiser Permanente Medicare plan

The dependent eligibility rules described in the "Eligibility as a Dependent" section also apply if you are a subscriber under a Kaiser Permanente Medicare plan offered by your Group (ask your Group about your membership options). All of your dependents who are enrolled under this or any other non-Medicare evidence of coverage offered by your Group must be enrolled under the same non-Medicare evidence of coverage. A "non-Medicare" evidence of coverage is one that does not require members to have Medicare.

Persons barred from enrolling

You cannot enroll if you have had your entitlement to receive services through Health Plan terminated for cause.

Members with Medicare and retirees

This *EOC* is not intended for most Medicare beneficiaries and some Groups do not offer coverage to retirees. If, during the term of this *EOC*, you are (or become) eligible for Medicare or you retire, ask your Group about your membership options as follows:

- If a Subscriber who has Medicare Part B retires and the Subscriber's Group has a Kaiser Permanente Senior Advantage plan for retirees, the Subscriber should enroll in the plan if eligible
- If the Subscriber has dependents who have Medicare and your Group has a Kaiser Permanente Senior Advantage plan (or of one our other plans that require members to have Medicare), the Subscriber may be able to enroll them as dependents under that plan
- If the Subscriber retires and your Group does not offer coverage to retirees, you may be eligible to continue membership as described in the "Continuation of Membership" section
- If federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary, your coverage under this *EOC* will be the same as it would be if you had not become eligible for Medicare. However, you may also be eligible to enroll in Kaiser Permanente Senior Advantage through your Group if you have Medicare Part B
- If you are (or become) eligible for Medicare and are in a class of beneficiaries for which your Group's health care coverage is secondary to Medicare, you should consider enrollment in Kaiser Permanente Senior Advantage through your Group if you are eligible
- If none of the above applies to you and you are eligible for Medicare or you retire, ask your Group about your membership options

Note: If you are enrolled in a Medicare plan and lose Medicare eligibility, you may be able to enroll under this *EOC* if permitted by your Group (ask your Group for details).

When Medicare is primary

Your Group's Premiums may increase if you are (or become) eligible for Medicare Part A or B as primary coverage, and you are not enrolled through your Group in Kaiser Permanente Senior Advantage for any reason (even if you are not eligible to enroll or the plan is not available to you).

When Medicare is secondary

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

Medicare late enrollment penalties

If you become eligible for Medicare Part B and do not enroll, Medicare may require you to pay a late enrollment penalty if you later enroll in Medicare Part B. However, if you delay enrollment in Part B because you or your spouse are still working and have coverage through an employer group health plan, you may not have to pay the penalty. Also, if you are (or become)

eligible for Medicare and go without creditable prescription drug coverage (drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage) for a continuous period of 63 days or more, you may have to pay a late enrollment penalty if you later sign up for Medicare prescription drug coverage. If you are (or become) eligible for Medicare, your Group is responsible for informing you about whether your drug coverage under this *EOC* is creditable prescription drug coverage at the times required by the Centers for Medicare & Medicaid Services and upon your request.

How to Enroll and When Coverage Begins

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

If you are eligible to be a Dependent under this *EOC* but the subscriber in your family is enrolled under a Kaiser Permanente Senior Advantage evidence of coverage offered by your Group, the rules for enrollment of Dependents in this "How to Enroll and When Coverage Begins" section apply, not the rules for enrollment of dependents in the subscriber's evidence of coverage.

New employees

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

Effective date of coverage

The effective date of coverage for new employees and their eligible family Dependents is determined by your Group in accord with waiting period requirements in state and federal law. Your Group is required to inform the Subscriber of the date your membership becomes effective. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: If the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

Open enrollment

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

Special enrollment

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

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

Special enrollment due to new Dependents

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

The effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber. Enrollments of newly acquired Dependent children are effective as follows:

- Enrollments due to birth are effective on the date of birth
- Enrollments due to adoption are effective on the date of adoption
- Enrollments due to placement for adoption or foster care are effective on the date you or your Spouse have newly assumed a legal right to control health care

Special enrollment due to loss of other coverage

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, if all of the following are true:

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

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

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

Special enrollment due to court or administrative order

Within 30 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application.

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

Special enrollment due to eligibility for premium assistance

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

Special enrollment due to reemployment after military service

If you terminated your health care coverage because you were called to active duty in the military service, you may be able to reenroll in your Group's health plan if required by state or federal law. Ask your Group for more information.

Other special enrollment events

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

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

- a qualified individual was not enrolled in the qualified health plan that the individual selected
- a qualified individual is eligible for, but is not receiving, advance payments of the premium tax credit or cost share reductions

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

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

How to Obtain Covered Benefits

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

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Covered Benefits" section
- Covered Benefits received outside of your Service Area as described under "Receiving Care Outside of Your Home Region" in this "How to Obtain Covered Benefits" section
- COVID-19 services as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Pharmacy Services," and "Preventive Services" in the "Covered Benefits" section
- Emergency ambulance services as described under "Ambulance Services" in the "Covered Benefits" section
- Emergency Services and Care, Post-Stabilization Care, and Out-of-Area Urgent Care as described in this "How to Obtain Covered Benefits" section
- Hospice care as described under "Hospice Care" in the "Covered Benefits" section

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

Routine Care

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

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

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

Urgent Care

Inside your Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition or Psychiatric Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For appointment and advice phone numbers, refer to our Provider Directory or call Member Services.

Out-of-Area Urgent Care

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

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

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non–Plan Providers if the services would have been covered under this *EOC* if you had received them from Plan Providers.

To obtain follow-up care from a Plan Provider, call the appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call Member Services. We do not cover follow-up care from Non–Plan Providers after you no longer need Urgent Care, except for durable medical equipment covered under this *EOC*. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Covered Benefits" section. If you require durable medical equipment related to your Urgent Care after receiving Out-of-Area Urgent Care, your provider must obtain prior authorization as described under "Prior Authorization Procedure for Certain Referrals and Services" in the "How to Obtain Covered Benefits" section.

Emergency Services and Care

If you have an Emergency Medical Condition or Psychiatric Emergency Medical Condition, call 911 (where available) or go to the nearest emergency department. If you are experiencing a mental health crisis, you can also call or text 988 to be connected to a trained crisis counselor. You do not need prior authorization for Emergency Services and Care. When you have an Emergency Medical Condition or Psychiatric Emergency Medical Condition, we cover Emergency Services and Care you receive from Plan Providers or Non–Plan Providers anywhere in the world.

Emergency Services and Care are available from Plan Hospital emergency departments 24 hours a day, seven days a week.

Post-Stabilization Care

When you receive Post-Stabilization Care from a Non-Plan Provider inside of California, or from a Cigna Healthcare PPO Network facility outside of a Kaiser Permanente State

When you receive Emergency Services and Care, we cover Post-Stabilization Care from a Non–Plan Provider only if prior authorization for the care is obtained as described below, or if otherwise required by applicable law ("prior authorization" means that the services must be approved in advance).

- **Post-Stabilization Care authorization at a Cigna Healthcare PPO Network facility outside of a Kaiser Permanente State:** If you are outside of a Kaiser Permanente state and you were treated at a Cigna Healthcare PPO Network facility for an Emergency Medical Condition or Psychiatric Emergency Medical Condition, Cigna Payer Solutions is responsible for authorizing any Post-Stabilization Care
- **Post-Stabilization Care authorization from other Non-Plan Providers (including Cigna Healthcare PPO Network facilities inside a Kaiser Permanente State):** To request prior authorization, the Non–Plan Provider must call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non–Plan Provider. If we determine that you require Post-Stabilization Care and that this care is part of your covered benefits, we will authorize your care from the Non–Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non–Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered

  Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover Post-Stabilization Care or related transportation provided by Non–Plan Providers that has not been authorized. If you receive care from a Non–Plan Provider that we have not authorized, you may have to pay the full cost of that care. If you are admitted to a Non–Plan Hospital or independent freestanding emergency department, notify us as soon as possible by calling **1-800-225-8883** or the notification phone number on your ID card

When you receive Post-Stabilization Care from a Non-Plan Provider in Nevada that is not a Cigna Healthcare PPO Network facility

When you receive Emergency Services and Care, we cover Post-Stabilization Care from a Non-Plan Provider in Nevada that is not a Cigna Healthcare PPO Network facility only if prior authorization for the care is obtained as described below, or if otherwise required by applicable law ("prior authorization" means that the services must be approved in advance).

- **Post-Stabilization Care authorization at Non-Plan Provider in Nevada:** If you are inside Nevada and you were treated at Non-Plan Provider that is not a Cigna Healthcare PPO Network facility for an Emergency Medical Condition or Psychiatric Emergency Medical Condition, Cigna Payer Solutions is responsible for authorizing any Post-Stabilization Care

When you receive Post-Stabilization Care from a Non-Plan Provider that is not a Cigna Healthcare PPO Network provider outside of California and Nevada

After you receive Emergency Services and Care from Non-Plan Providers and your condition is Stabilized, Post-Stabilization Care is considered Emergency Services and Care under federal law if either of the following are true:

- Your treating physician determines that you are not able to travel using nonemergency transportation to an available Plan Provider located within a reasonable travel distance, taking into account your medical condition; or
- Your treating physician, using appropriate medical judgment, determines that you are not in a condition to receive, and/or to provide consent to, the Non-Plan Provider's notice and consent form, in accordance with applicable state informed consent law

If the Post-Stabilization Care is considered Emergency Services and Care under the criteria above, prior authorization for Post-Stabilization Care at a Non-Plan Provider will not be required.

If the Post-Stabilization Care is not considered Emergency Services and Care, the services are not covered unless you have received prior authorization from Health Plan as described under "Post-Stabilization Care authorization from other Non-Plan Providers (including Cigna Healthcare PPO Network facilities inside a Kaiser Permanente State)" above. Non-Plan Providers outside of California may provide notice and seek your consent to waive your balance billing protections under the federal No Surprises Act, if such consent is permissible under applicable state informed consent law. If you consent to waive your balance billing protections and receive services from the Non-Plan Provider, you will have to pay the full cost of the services.

Not Sure What Kind of Care You Need?

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

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

You can reach one of these licensed health care professionals by calling the appointment or advice phone number (for phone numbers, refer to our Provider Directory or call Member Services). When you call, a trained support person may ask you questions to help determine how to direct your call.

Your Personal Plan Physician

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

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians. However, if you choose a specialist who is not designated as a Primary Care Physician as your personal Plan Physician, the Cost Share for a Physician Specialist Visit will apply to all visits with the specialist except for routine preventive visits listed under "Preventive Services" in the "Covered Benefits" section.

To learn how to select or change to a different personal Plan Physician, visit our website at **kp.org** or call Member Services. Refer to our Provider Directory for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, call Member Services. You can change your personal Plan Physician at any time for any reason.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, dermatology, and

physical, occupational, and speech therapies. Also, a Plan Physician must refer you before you can get Behavioral Health Treatment for Autism Spectrum Disorder covered under "Mental Health Services" in the "Covered Benefits" section. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

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

A Plan Physician must refer you before you can get care from a specialist in urology except that you do not need a referral to receive services related to sexual or reproductive health, such as a vasectomy.

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

- The provider may have to get prior authorization for certain services in accord with "Prior Authorization Procedure for Certain Referrals and Services"
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

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

Prior Authorization Procedure for Certain Referrals and Services

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

The majority of services generally do not require prior authorization. The following are examples of services that do require prior authorization by the Health Plan for the services to be covered ("prior authorization" means that the Health Plan must approve the services in advance):

- Acupuncture services
- Durable medical equipment, ostomy and urological supplies, and prosthetic and orthotic devices
- Dental anesthesia
- Referrals to Non-Plan Providers

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

Refer to "Post-Stabilization Care" under "Emergency Services and Care" in this "How to Obtain Covered Benefits" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

The prior authorization process includes the use of UM criteria. These criteria were developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with clinical expertise. UM criteria are periodically updated to keep pace with changes in medical technology and clinical practice.

If your Plan Physician prescribes a Service subject to UM, they will submit a written referral in accord with the UM process described in this "Prior Authorization Procedure for Certain Referrals and Services" section. If UM criteria do not specify that the prescribed item is Medically Necessary for your medical condition, the referral will be submitted to the Health Plan, which will make an authorization decision as described under "Health Plan's decision time frames" in this "Prior Authorization Procedure for Certain Referrals and Services" section.

Additional information about utilization review determination criteria for mental health services or substance use disorder treatment

Utilization review determination criteria and any education program materials for individuals making authorization decisions related to mental health services or substance use disorder treatment are available at **kp.org** at no cost.

Health Plan's decision time frames

The applicable Health Plan designee will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after receiving all of the information (including additional examination and test results) reasonably necessary to make the decision, except that decisions about urgent services will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If the Health Plan needs more time to make the decision because it doesn't have information reasonably necessary to make the decision, or because it has requested consultation by a particular specialist, you and your treating physician will be informed about the additional information, testing, or specialist that is needed, and the date that the Health Plan expects to make a decision.

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the services are authorized, your physician will be informed of the scope of the authorized services. If the Health Plan does not authorize all of the services, Health Plan will send you a written decision and explanation within two business days after the decision is made. Any written criteria that the Health Plan uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request and at no cost.

If the Health Plan does not authorize all of the services requested and you want to appeal the decision, you can file a grievance as described under "Grievances" in the "Dispute Resolution" section.

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

Completion of Services from Non–Plan Providers

New Member

If you are currently receiving Covered Benefits from a Non–Plan Provider in one of the cases listed below under "Eligibility," and you were covered under another health plan when you began receiving the services, but your prior plan's coverage of the provider's services has ended or will end when your coverage with us becomes effective, you may be eligible for limited coverage of that Non–Plan Provider's services.

Terminated provider

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

Eligibility

The cases that are subject to this completion of services provision are:

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these services until the acute condition ends
- Serious chronic conditions until the earlier of (1) 12 months from your effective date of coverage if you are a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - it persists without full cure
  - it worsens over an extended period of time
  - it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these services for the duration of the pregnancy and immediate postpartum care
- Mental health conditions in pregnant Members that occur, or can impact the Member, during pregnancy or during the postpartum period including, but not limited to, postpartum depression. We may cover completion of these services for up to 12 months from the mental health diagnosis or from the end of pregnancy, whichever occurs later
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these services for the duration of the illness
- Children under age 3. We may cover completion of these services until the earlier of (1) 12 months from the child's effective date of coverage if the child is a new Member, (2) 12 months from the termination

date of the terminated provider, or (3) the child's third birthday

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

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

- Your Health Plan coverage is in effect on the date you receive the services
- For new Members, your prior plan's coverage of the provider's services has ended or will end when your coverage with us becomes effective
- You are receiving Covered Benefits in one of the cases listed above from a Non–Plan Provider on your effective date of coverage if you are a new Member, or from the terminated Plan Provider on the provider's termination date
- For new Members, when you enrolled in Health Plan, you did not have the option to continue with your previous health plan or to choose another plan (including an out-of-network option) that would cover the services of your current Non–Plan Provider
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing services inside your Service Area (the requirement that the provider agree to providing services inside your Service Area doesn't apply if you were receiving Covered Benefits from the provider outside your Service Area when the provider's contract terminated)
- The services to be provided to you would be Covered Benefits under this *EOC* if provided by a Plan Provider
- You request completion of services in accord with the "Completion of Covered Services" policy on **kp.org**

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

More information

For more information about this provision, or to request the services or a copy of our "Completion of Covered Services" policy, call Member Services.

Travel and Lodging for Certain Services

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

- If Medical Group refers you to a provider that is more than 50 miles from where you live for certain specialty services such as bariatric surgery, complex thoracic surgery, transplant nephrectomy, or inpatient chemotherapy for leukemia and lymphoma
- If Medical Group refers you to a provider that is outside your Service Area for certain specialty services such as a transplant or transgender surgery
- If you are outside of California and you need an abortion on an emergency or urgent basis, and the abortion can't be obtained in a timely manner due to a near total or total ban on Health Care Providers' ability to provide such services

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

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an Appropriately Qualified Health Care Provider for your condition. If there isn't a Plan Physician who is an Appropriately Qualified Health Care Provider for your condition, Member Services will help you arrange a consultation with a Non–Plan Physician for a second opinion.

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

- Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results

- The Plan Physician is unable to diagnose the condition
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

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

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

Contracts with Plan Providers

How Plan Providers are paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital services for Members, visit our website at **kp.org** or call Member Services.

Financial liability

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

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

Termination of a Plan Provider's contract

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

Provider groups and hospitals

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

Receiving Care Outside of Your Home Region

For information about your coverage when you are away from home, visit our website at **kp.org/travel**. You can also call the Away from Home Travel Line at **1-951-268-3900** 24 hours a day, seven days a week (closed holidays).

Receiving care in another Kaiser Permanente Service Area

If you are visiting in another Kaiser Permanente Service Area or service area of a Health Plan affiliate, you may receive certain Covered Benefits from designated providers in that other Kaiser Permanente Service Area or service area of a Health Plan affiliate, subject to exclusions, limitations, prior authorization or approval requirements, and reductions. For more information about receiving Covered Benefits in another Kaiser Permanente Service Area or service area of a Health Plan affiliate, including provider and facility locations, visit **kp.org/travel** or call our Away from Home Travel Line at **1-951-268-3900** 24 hours a day, seven days a week (closed holidays).

For Covered Benefits you receive in another Kaiser Permanente Service Area or service area of a Health Plan affiliate, you pay the Cost Share required for services provided by a Plan Provider inside your Service Area as described in this *EOC*.

Receiving care outside of any Kaiser Permanente Service Area

If you are traveling outside of any Kaiser Permanente Service Area, we cover Emergency Services and Care and Urgent Care as described in this "How to Obtain Services" section.

Your ID Card

Each Member's Kaiser Permanente ID card has a medical record number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. When you get care, bring your ID card and a photo ID. Your medical record number is used to identify your medical records and membership information. Your medical record number should never

change. Call Member Services if we ever inadvertently issue you more than one medical record number or if you need to replace your ID card.

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

Timely Access to Care

Standards for appointment availability

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

- Urgent care appointment: within 48 hours
- Routine (non-urgent) primary care appointment (including adult/internal medicine, pediatrics, and family medicine): within 10 business days
- Routine (non-urgent) specialty care appointment with a physician: within 15 business days
- Routine (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician: within 10 business days
- Follow-up (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician, for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition: within 10 business days

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

The standards for appointment availability do not apply to Preventive Services. Your Plan Provider may recommend a specific schedule for Preventive Services, depending on your needs. Except as specified above for mental health care and substance use disorder treatment, the standards also do not apply to periodic follow-up care for ongoing conditions or standing referrals to specialists.

Timely access to telephone assistance

DMHC developed the following standards for answering telephone questions:

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

Interpreter services

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

Access to mental health services and substance use disorder treatment

State law requires evidence of coverage documents to include the following notice:

You have a right to receive timely and geographically accessible Mental Health/Substance Use Disorder (MH/SUD) services when you need them. If Kaiser Permanente fails to arrange those services for you with an appropriate provider who is in the health plan's network, the health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you do not have to pay anything other than your ordinary in-network cost-sharing.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days from when you requested the services from the health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if the health plan does not require prior authorization for the appointment) or within 96 hours (if the health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes

and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

If you have questions about how to obtain MH/SUD services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on the back of your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at http://www.healthhelp.ca.gov to request assistance in obtaining MH/SUD services.

Getting Assistance

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

Member Services

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

- Your Health Plan benefits
- How to make your first medical appointment
- What to do if you move
- How to replace your Kaiser Permanente ID card

You can reach Member Services in the following ways:

Call **1-800-464-4000 (**English and more than 150 languages using interpreter services**)**
1-800-788-0616 (Spanish**)**
1-800-757-7585 (Chinese dialects**)**
TTY users call **711**
24 hours a day, seven days a week (closed holidays)

Visit Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

Write Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

Website kp.org

Cost Share estimates

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

Plan Facilities

Plan Facilities are listed in the Provider Directory for your Service Area. The directory describes the types of Covered Benefits that are available from each Plan Facility, because some facilities provide only specific types of Covered Benefits.

The Provider Directory is available on our website at kp.org/facilities. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, call Member Services.

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

- All Plan Hospitals provide inpatient services and are open 24 hours a day, seven days a week
- Emergency Services and Care are available from Plan Hospital emergency departments (for emergency department locations, refer to our Provider Directory or call Member Services)
- Same-day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call Member Services)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services office (for locations, refer to our Provider Directory or call Member Services)

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 Kaiser Permanente Member Services at 1-800-464-4000 (TTY users call 711), to ensure that you can obtain the health care services that you need.

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.

Covered Benefits

This section describes Covered Benefits under this *EOC*.

Services are covered under this *EOC* as specifically described in this *EOC*. Services that are not specifically described in this *EOC* are not covered, except as required by state or federal law. Services are subject to exclusions and limitations described in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. Except as otherwise described in this *EOC*, all of the following conditions must be satisfied:

- You are a Member on the date that you receive the services
- The services are Medically Necessary
- The services are one of the following:
  - Preventive Services
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Covered Benefits" section
  - other health care items and services
- The services are provided, prescribed, authorized, or directed by a Plan Physician, except for:
  - Covered Benefits received outside of your Service Area, as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Covered Benefits" section
  - COVID-19 services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Pharmacy Services," and "Preventive Services" below
  - drugs prescribed by dentists, as described under "Outpatient Pharmacy Services" below
  - emergency ambulance services, as described under "Ambulance Services" below
  - Emergency Services and Care, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "How to Obtain Covered Benefits" section
- You receive the services from Plan Providers inside your Service Area, except for:
  - authorized referrals, as described under "Getting a Referral" in the "How to Obtain Covered Benefits" section
  - Covered Benefits received outside of your Service Area, as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Covered Benefits" section
  - COVID-19 services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Pharmacy Services," and "Preventive Services" below
  - emergency ambulance services, as described under "Ambulance Services" below
  - Emergency Services and Care, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "How to Obtain Covered Benefits" section
  - hospice care, as described under "Hospice Care" below
- The Health Plan has given prior authorization for the services, if required, as described under "Prior Authorization Procedure for Certain Referrals and Services" in the "How to Obtain Covered Benefits" section

Refer to:

- The "How to Obtain Covered Benefits" section for information about how to obtain covered Emergency Services and Care, Post-Stabilization Care, and Out-of-Area Urgent Care

- Our Provider Directory for the types of Covered Benefits that are available from each Plan Facility, because some facilities provide only specific types of Covered Benefits

Your Cost Share

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

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

Refer to the "Cost Share Summary" section of this *EOC* for the amount you will pay for Covered Benefits.

General rules, examples, and exceptions

Your Cost Share for Covered Benefits will be the Cost Share in effect on the date you receive the services, except as follows:

- If you are receiving covered hospital inpatient or Skilled Nursing Facility Services on the effective date of this *EOC*, you pay the Cost Share in effect on your admission date until you are discharged if the services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Share in effect on the date you receive the services
- For items ordered in advance, you pay the Cost Share in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Share when the item is ordered. For Prescription Drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription

Cost Share for services received by newborn children of a Member

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

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

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

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

exam your provider requests a consultation with a specialist. You may be asked to pay (or you will be billed for) your Cost Share for the consultation with the specialist

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

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

In some cases, a Non–Plan Provider may be involved in the provision of Covered Benefits at a Plan Facility or a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the Covered Benefits you receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the services and file a claim for reimbursement. For information on how to file a claim, see the "Post-Service Claims and Appeals" section.

Refer to "Emergency Services and Care and Urgent Care" in this "Covered Benefits" section for more information about when you may be billed for Emergency Services and Care, Post-Stabilization Care, and Out-of-Area Urgent Care.

Reimbursement for COVID-19 services from Non-Plan Providers

If you receive covered COVID-19 services from Non-Plan Providers as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Pharmacy Services," and "Preventive Services" in the "Covered Benefits" section, you may have to pay for the services and file a claim for reimbursement. For information on how to file a claim, see "Initial Claims" in the "the "Post-Service Claims and Appeals" section.

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

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

Provider fees

Some Plan Providers may charge you a fee for missed appointments without 24 hour advance notice, except in the case of an emergency.

Non-covered services

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

When a service is not covered, all services related to the non-covered service are also not covered, except for services we would otherwise cover to treat complications of the non-covered service, or as required by law. For example, if you have a non-covered cosmetic surgery, we would not cover services you receive in preparation for the surgery or for follow-up care. If you later suffer a

life-threatening complication such as a serious infection, we would cover any services that we would otherwise cover to treat that complication.

Benefit limits
Some benefits may include a limit on the number of visits, days, treatment cycles, or dollar amount that will be covered under your plan during a specified time period. If a benefit includes a limit, this will be indicated in the "Cost Share Summary" section of this *EOC*. The time period associated with a benefit limit may not be the same as the term of this *EOC*. We will count all Covered Benefits you receive during the benefit limit period toward the benefit limit, including services you received under a prior Health Plan *EOC* (as long as you have continuous coverage with Health Plan). Note: We will not count services you received under a prior Health Plan *EOC* when you first enroll in individual plan coverage or a new employer group's plan, when you move from group to individual plan coverage (or vice versa), or when you received services under a Kaiser Permanente Senior Advantage evidence of coverage. If you are enrolled in the Kaiser Permanente POS Plan, refer to your KPIC *Certificate of Insurance* and *Schedule of Coverage* for benefit limits that apply to your separate indemnity coverage provided by the Kaiser Permanente Insurance Company ("KPIC").

Getting an estimate of your Cost Share

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

- If you have a Plan Deductible and would like an estimate for services that are subject to the Plan Deductible, call **1-800-390-3507** (TTY users call **711**) Monday through Friday 6 a.m. to 5 p.m. Refer to the "Cost Share Summary" section of this *EOC* to find out if you have a Plan Deductible
- For all other Cost Share estimates, call **1-800-464-4000** (TTY users call **711**) 24 hours a day, seven days a week (closed holidays)

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

Drug Deductible

This *EOC* does not include a Drug Deductible.

Plan Deductible

This *EOC* does not include a Plan Deductible.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for Covered Benefits that you receive, after you meet any applicable deductible, is described in this *EOC*.

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

Plan Out-of-Pocket Maximum

There is a limit to the total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for Covered Benefits that you receive in the same Accumulation Period. The services that apply to the Plan Out-of-Pocket Maximum are described under the "Payments that count toward the Plan Out-of-Pocket Maximum" section below. Refer to the "Cost Share Summary" section of this *EOC* for your applicable Plan Out-of-Pocket Maximum amounts.

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

Payments that count toward the Plan Out-of-Pocket Maximum
Any payments you make toward the Plan Deductible or Drug Deductible, if applicable, apply toward the maximum.

Most Copayments and Coinsurance you pay for Covered Benefits apply to the maximum, however some may not. To find out whether a Copayment or Coinsurance for a Covered Benefits will apply to the maximum refer to the "Cost Share Summary" section of this *EOC*.

Accrual toward deductibles and out-of-pocket maximums

To see how close you are to reaching your deductibles, if any, and out-of-pocket maximums, use our online Out-of-Pocket Summary tool at **kp.org** or call Member

Services. We will provide you with accrual balance information for every month that you receive services until you reach your individual out-of-pocket maximums or your Family reaches the Family out-of-pocket maximums.

We will provide accrual balance information by mail unless you have opted to receive notices electronically. You can change your document delivery preferences at any time at **kp.org** or by calling Member Services.

Administered Drugs and Products

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

- Whole blood, red blood cells, plasma, and platelets
- Allergy antigens (including administration)
- Cancer chemotherapy drugs and adjuncts
- Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood
- Other administered drugs and products

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

For the following services, refer to these sections

- Administered contraceptives (refer to "Reproductive Health Services")
- All other administered drugs that are Preventive Services, including immunizations (refer to "Preventive Services")

Ambulance and Non-Emergency Medical Transportation ("NEMT") Services

Emergency ambulance services

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

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

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

Non-emergency ambulance services

Inside your Service Area, we cover non-emergency ambulance services if a Plan Physician determines that your condition requires the use of services that only a licensed ambulance can provide and that the use of other means of transportation would endanger your health. These services are covered only when the vehicle transports you to or from Covered Benefits.

NEMT services

We cover NEMT services, when they are received inside your Service Area and provided by Health Plan-designated transportation carriers, such as a psychiatric transport van, stretcher/gurney van, or wheelchair van. Such NEMT services are covered only if both of the following are true:

- The services are ordered by a Plan Physician
- The services are Medically Necessary

Covered NEMT services do not include transportation by car, taxi, bus, minivan, or any other means (other than the services described in this "NEMT services" section).

Bariatric Surgery

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

- You complete the Medical Group–approved pre-surgical educational preparatory program regarding

lifestyle changes necessary for long term bariatric surgery success

- A Plan Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary

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

For the following services, refer to these sections

- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")

Dental and Orthodontic Services

We do not cover most dental and orthodontic services under this *EOC*, such as dental cleanings, dental X-rays, appliances, and implants, but we do cover some dental and orthodontic services as described in this "Dental and Orthodontic Services" section.

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

Dental services for radiation treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a Plan Physician provides the services or if the Medical Group provides a referral to a dentist for those services.

Dental services for transplants

We cover dental services that are Medically Necessary to free the mouth from infection in order to prepare for a transplant covered under "Transplant Services" in this "Covered Benefits" section, if a Plan Physician provides the services or if the Medical Group provides a referral to a dentist for those services.

Dental anesthesia

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

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

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

Dental and orthodontic services for cleft palate

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

- The services are an integral part of a reconstructive surgery for cleft palate that we are covering under "Reconstructive Surgery" in this "Covered Benefits" section ("cleft palate" includes cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate)
- A Plan Provider provides the services or the Medical Group provides a referral to a Non–Plan Provider who is a dentist or orthodontist (as described under "Prior Authorization Procedure for Certain Referrals and Services" in the "How to Obtain Covered Benefits" section)

For the following services, refer to these sections

- Accidental injury to teeth (refer to "Injury to Teeth")
- Office visits not described in the "Dental and Orthodontic Services" section (refer to "Office Visits")
- Outpatient imaging, laboratory, and other diagnostic and treatment services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient administered drugs (refer to "Administered Drugs and Products"), except that we cover outpatient administered drugs under "Dental anesthesia" in this "Dental and Orthodontic Services" section
- Prescription Drugs (refer to "Outpatient Pharmacy Services")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis Care

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

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

After you receive appropriate training at a dialysis facility we designate, we also cover equipment and medical supplies required for home hemodialysis and home peritoneal dialysis inside your Service Area. Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

Covered dialysis care does not include the following services:

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

If you have end-stage renal disease ("ESRD"), you may be eligible for Original Medicare Part B. If you choose to enroll in Original Medicare Part B, Medicare may assist with your Member Cost Share. See "Medicare Coverage" in the "Coordination of Benefits" section. As soon as you are enrolled in Original Medicare Part B, we offer a program designed to help you with your Original Medicare Part B premiums for as long as you are enrolled in this plan, eligible for and enrolled in Original Medicare Part B due to ESRD. To learn more about this program and how to enroll, call Member Services.

For the following services, refer to these sections

- Durable medical equipment for home use (refer to "Durable Medical Equipment ("DME") for Home Use")
- Hospital inpatient services (refer to "Hospital Inpatient Services")
- Office visits not described in the "Dialysis Care" section (refer to "Office Visits")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")
- Telehealth Visits (refer to "Telehealth Visits")

Durable Medical Equipment ("DME") for Home Use

DME coverage rules

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

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

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

- Your *EOC* includes coverage for the requested DME item
- A Plan Physician has prescribed the DME item for your medical condition
- The item has been approved for you through the Health Plan's prior authorization process, as described under "Prior Authorization Procedure for Certain Referrals and Services" in the "How to Obtain Covered Benefits" section
- The services are provided inside your Service Area

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

Covered DME for home use does not include the following services:

- Comfort, convenience, or luxury equipment or features except for retail-grade milk pumps as described under "Lactation supplies" in this "Durable Medical Equipment ("DME") for Home Use" section
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including

devices intended to provide additional support for recreational or sports activities)
- Hygiene equipment
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (except diabetes glucose monitors and their supplies and pulse oximeters)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to loss, theft, or misuse

Base DME Items

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

- Bone stimulator
- Canes (standard curved handle or quad) and replacement supplies
- Cervical traction (over door)
- Crutches (standard or forearm) and replacement supplies
- Dry pressure pad for a mattress
- Glucose monitors for diabetes blood testing 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
- IV pole
- Nebulizer and supplies
- Peak flow meters
- Phototherapy blankets for treatment of jaundice in newborns

Supplemental DME items

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

Lactation supplies

We cover one retail-grade milk pump (also known as a breast pump) per pregnancy and associated supplies, as listed on our website at **kp.org/prevention**. We will decide whether to rent or purchase the item and we choose the vendor. We cover this pump for convenience purposes. The pump is not subject to prior authorization requirements.

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

Outside your Service Area

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

- Canes (standard curved handle)
- Crutches (standard)
- Glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
- Insulin pumps and supplies to operate the pump, after completion of training and education on the use of the pump
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

For the following services, refer to these sections

- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Pharmacy Services")
- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Durable medical equipment related to an Emergency Medical Condition or Urgent Care episode (refer to "Post-Stabilization Care" and "Out-of-Area Urgent Care")
- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Insulin and any other drugs administered with an infusion pump (refer to "Outpatient Pharmacy Services")

Emergency Services and Care and Urgent Care

We cover the following services:

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

Your Cost Share

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

- If you receive Emergency Services and Care in the emergency department of a Non–Plan Hospital, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Care and Urgent Care"
- If we gave prior authorization for inpatient Post-Stabilization Care in a Non–Plan Hospital, you pay the Cost Share for hospital inpatient services as described in the "Cost Share Summary" under "Hospital inpatient services"
- If we gave prior authorization for durable medical equipment after discharge from a Non–Plan Hospital, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"
- If you receive COVID-19 laboratory testing or immunizations in the emergency department, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Care and Urgent Care"
- If you obtain a prescription in the emergency department related to your Emergency Medical Condition or Psychiatric Emergency Medical Condition, you pay the Cost Share for "Most items" in the "Cost Share Summary" under "Outpatient pharmacy services" in addition to the Cost Share for the emergency department visit

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

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non–Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described in the "Cost Share Summary" under "Emergency Services and Care and Urgent Care"
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described in the "Cost Share Summary" under "Outpatient imaging, laboratory, and other diagnostic and treatment services," in addition to the Cost Share for the Urgent Care evaluation
- If the Out-of-Area Urgent Care you receive includes a COVID-19 test, you may have to pay the Cost Share for a COVID-19 test as described in the "Cost Share Summary" under "Outpatient imaging, laboratory, and other diagnostic and treatment services," in addition to the Cost Share for the Urgent Care evaluation
- If you obtain a prescription as part of an Out-of-Area Urgent Care visit related to the condition for which you obtained Urgent Care, you pay the Cost Share for "Most items" in the "Cost Share Summary" under "Outpatient pharmacy services" in addition to the Cost Share for the Urgent Care evaluation
- If we gave prior authorization for durable medical equipment provided as part of Out-of-Area Urgent Care, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"

Note: If you receive Urgent Care in an emergency department, you pay the Cost Share for an emergency department visit as described in the "Cost Share Summary" under "Emergency Services and Care and Urgent Care."

If a Non-Plan Provider does not agree to bill us, you may have to pay for the services and file a claim for reimbursement. Also, you may be required to pay and file a claim for any services prescribed by a Non–Plan Provider as part of covered Emergency Services and Care, Post-Stabilization Care, or Out-of-Area Urgent Care even if you receive the services from a Plan Provider, such as a Plan Pharmacy. For information on how to file a claim, see the "Post-Service Claims and Appeals" section.

For the following services, refer to these sections

- Abortion and abortion-related services (refer to "Reproductive Health Services")

Fertility Services (pending regulatory approval)

We cover the services described in this section under the following circumstances:

- The covered Member must be an Intended Parent who has an Infertility diagnosis
- Any third-party donors or Gestational Carriers must not be the Intended Parent

We cover the following Fertility Services subject to the limits described in this section:

- Diagnosis and treatment of Infertility
- Fertility Services including artificial insemination and in vitro fertilization (IVF)
  - ♦ Oocyte (egg) and sperm retrieval or procurement of donor materials as described below
  - ♦ Other associated imaging services, laboratory Services, and office visits
  - ♦ Transfer of fresh and cryopreserved embryo(s)
- Cryopreservation and storage
- Any other Fertility Services to treat Infertility consistent with established medical practices and the most current professional guidelines published by American Society for Reproductive Medicine (ASRM)

The following covered Fertility Services are subject to treatment limits:

- Oocyte retrieval or procurement of donor materials is limited to three attempts per lifetime
  - ♦ Procurement of donor oocytes is limited to one cohort per active course of fertility treatment
- Sperm retrieval or procurement of donor materials limited to three attempts per lifetime
  - ♦ Procurement of donor sperm is limited to one vial of sperm per active course of fertility treatment
- Cryopreserved donor materials (oocytes, sperm, or embryos) must be obtained from a cryobank with a valid California tissue bank license
- Embryo transfers are limited to the transfer of one embryo at a time per active course of fertility treatment
- Storage is limited to 5 years per lifetime (or until your enrollment terminates, if earlier than 5 years) from the time genetic material is first cryopreserved

If you reach the treatment limits for oocyte or sperm retrievals, we will not cover any services related to additional oocyte or sperm retrievals, including Prescription Drugs.

Donors and Gestational Carriers

Coverage for third party Fertility Services involving live donors or Gestational Carriers requires an Assisted Reproduction Agreement to be executed prior to the Intended Parent's third-party donor or Gestational Carrier receiving Fertility Services. Covered Fertility Services received by donors and Gestational Carriers are accumulated towards the Intended Parent's coverage and any applicable cost share is accumulated to the Intended Parent's deductible and/or out-of-pocket maximum. Retrieval services received by donors apply to the Intended Parent retrieval maximum and are subject to the limitations in the Intended Parent's *EOC*.

If the donor or Gestational Carrier is enrolled as a Member under this *EOC*, then any services received by the Gestational Carrier or donor that are not Fertility Services described in this section are covered in accordance with the terms and conditions of this *EOC*. However, Fertility Services and cost sharing are accumulated towards the coverage and retrieval maximums of the Intended Parent.

If the donor or Gestational Carrier is not enrolled as a Member under this *EOC*, then any services received by the Gestational Carrier or donor that are not related to Fertility Services are not covered under this *EOC*. Coverage is limited only to Fertility Services described in this section that are applied towards the Intended Parent's coverage. Any coverage for the Gestational Carrier based on their Assisted Reproductive Agreement with the Intended Parent terminates upon the confirmation of pregnancy.

You have a right to receive treatment for infertility and fertility services when you meet the requirements in Health and Safety Code section 1374.55.

If you have questions about how to obtain infertility treatment services or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on your health plan identification card; 2) call the California Department of Managed Health Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.DMHC.ca.gov to

request assistance in obtaining infertility treatment services.

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

Covered Fertility Services do not include the following services:

- Services that are not related to the Medically Necessary treatment of Infertility as defined in this *EOC*
  - ♦ Non-medical fees, including but not limited to legal fees, agency fees, shipping fees, travel fees, finder fees, broker fees, transport fees, other administrative costs, and compensation to a donor, Gestational Carrier and/or other third party involved in an Assisted Reproduction Agreement
  - ♦ Health care costs for any third party involved in an Assisted Reproduction Agreement that are not Medically Necessary Fertility Services
  - ♦ Any physical health or mental health screenings administered as part of the third-party selection process for a donor or Gestational Carrier prior to the execution of an Assisted Reproduction Agreement
- Services related to the procurement, cryopreservation, and storage of semen, oocytes, and embryos, except when part of covered Fertility Services

For the following services, refer to these sections

- Diagnostic services provided by Plan Providers who are not physicians, such as EKGs and EEGs (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Fertility preservation services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")

Fertility Preservation Services for Iatrogenic Infertility

Standard Fertility Preservation Services are covered in the following situations:

- A Plan Provider has recommended that you undergo covered treatment or receive Covered Benefits within the next 12 months that may cause iatrogenic infertility.
- You received covered treatment or Covered Benefits that may cause iatrogenic infertility, you were unable to undergo or complete fertility preservation due to your medical condition, and you face an ongoing risk for infertility caused by those treatments

Standard Fertility Preservation Services do not include diagnosis or treatment of Infertility and are not covered under the "Fertility Services" section.

We cover the following Standard Fertility Preservation Services:

- Retrieval of gametes:
  - ♦ Up to two cycles for oocyte retrieval for Members with ovaries per lifetime
  - ♦ Up to two attempts to collect sperm for Members with testicles per lifetime
- Up to two attempts of embryo creation per lifetime, except that we do not cover any costs associated with the retrieval of gametes from anyone other than the Member undergoing the medical treatment that may cause iatrogenic infertility
- Up to two attempts to retrieve gonadal tissue per lifetime
- Gonadal shielding or transposition during a procedure or treatment if not already included in the usual coverage for that procedure or treatment
- Any other Standard Fertility Preservation Services consistent with the established medical practices and professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine
- Cryopreservation and storage of sperm, oocytes, gonadal tissue, and embryos from a vendor that we select for the following time period based on your age on the date that the material is first cryopreserved:
  - ♦ for a Member who is under the age of 18: until the Member reaches age 26
  - ♦ for a Member who is 18 years or older but not yet 26 years old: until the Member reaches age 26 or for three years, whichever period is longer
  - ♦ for a Member who is 26 years or older: three years

Your coverage for cryopreservation storage from us ends when your membership terminates. If you change health plans during the cryopreservation storage period described above, you must notify your new health plan that you want them to cover storage starting from the effective date of your coverage in that plan. We will work with the new plan to coordinate transportation of stored material, if required. If you are still a Member when your storage period expires, you will receive a notice 90 days before the storage period expires that explains options for continued storage and potential out-of-pocket costs.

For covered Standard Fertility Preservation Services that you receive, you will pay the Cost Share you would pay if the services were not related to fertility preservation. For example, see "Outpatient surgery and outpatient procedures" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for outpatient procedures.

You have the right to receive standard fertility preservation services for iatrogenic infertility when you meet the requirements in Section 1300.74.551 of Title 28 of the California Code of Regulations. "Iatrogenic infertility" means infertility caused directly or indirectly by surgery, chemotherapy, radiation, or other medical treatment. If Kaiser Permanente fails to arrange those services for you with an appropriate provider who is in your health plan's network, your health plan must cover and arrange needed services for you from an out-of-network provider. If that happens, you will pay no more than in-network costsharing for the same services.

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days for primary care and 15 business days for specialist care from when you requested the services from your health plan. If you urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if your health plan does not require prior authorization for the appointment) or within 96 hours (if your health plan does require prior authorization).

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any licensed provider, even if the provider is not in your health plan's network. If you are enrolled in preferred provider organization (PPO) coverage, and your health plan can arrange care for you within the timeframes and within geographic standards, your voluntary use of out-of-network benefits may subject you to incur out-of-network charges.

If you have questions about how to obtain standard fertility preservation services for iatrogenic infertility or are having difficulty obtaining services you can: 1) call your health plan at the telephone number on your health plan identification card; 2) call the California Department of Managed Care's Help Center at 1-888-466-2219; or 3) contact the California Department of Managed Health Care through its website at www.DMHC.ca.gov to request assistance in obtaining standard fertility preservation services for iatrogenic infertility.

For the following services, refer to these sections

- Treatments and procedures to help you become a parent (refer to "Fertility Services")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")

Health Education

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

We also cover a variety of health education counseling, programs, and materials to help you take an active role in

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

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

Hearing Services

We cover the following:

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

Hearing aids

Hearing aids, tests to determine their efficacy, hearing tests to determine an appropriate hearing aid, and related services are not covered under this *EOC*. For internally implanted devices, see "Prosthetic and Orthotic Devices" in this "Covered Benefits" section.

For the following services, refer to these sections

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

Home Health Care

"Home health care" means services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists.

We cover home health care only if all of the following are true:

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

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

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

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

Covered home health care does not include the following services:

- 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

For the following services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder (refer to "Mental Health Services")
- Dialysis care (refer to "Dialysis Care")

- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Hospice Care

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

We cover the hospice services listed below only if all of the following requirements are met:

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

If all of the above requirements are met, we cover the following hospice services, if necessary for your hospice care:

- Plan Physician services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, and speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from a Plan Pharmacy. Certain drugs are limited to a maximum 30-day supply in any 30-day period (your Plan Pharmacy can tell you if a drug you take is one of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient services limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling

We also cover the following hospice services only during periods of crisis when they are Medically Necessary to achieve palliation or management of acute medical symptoms:

- Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
- Short-term inpatient services required at a level that cannot be provided at home

Hospital Inpatient Services

We cover the following inpatient services in a Plan Hospital, when the services are generally and customarily provided by acute care general hospitals inside your Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, refer to "Outpatient

Pharmacy Services" in this "Covered Benefits" section)

- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and other diagnostic and treatment services, including MRI, CT, and PET scans
- Whole blood, red blood cells, plasma, platelets, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, refer to "Office Visits" in this "Covered Benefits" section)
- Behavioral Health Treatment for Autism Spectrum Disorder
- Respiratory therapy
- Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation program)
- Medical social services and discharge planning

For the following services, refer to these sections

- Abortion and abortion-related services (refer to "Reproductive Health Services")
- Bariatric surgical procedures (refer to "Bariatric Surgery")
- Dental and orthodontic procedures (refer to "Dental and Orthodontic Services")
- Dialysis care (refer to "Dialysis Care")
- Fertility preservation services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Fertility Services (refer to "Fertility Services")
- Hospice care (refer to "Hospice Care")
- Mental health services (refer to "Mental Health Services")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Reconstructive surgery services (refer to "Reconstructive Surgery")
- Services in connection with a clinical trial (refer to "Services in Connection with a Clinical Trial")
- Skilled inpatient services in a Plan Skilled Nursing Facility (refer to "Skilled Nursing Facility Care")
- Substance use disorder treatment services (refer to "Substance Use Disorder Treatment")
- Transplant services (refer to "Transplant Services")

Injury to Teeth

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

Mental Health Services

We cover services specified in this "Mental Health Services" section only when the services are for the prevention, diagnosis, or treatment of Mental Health Conditions. A "Mental Health Condition" is a mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders.*

Outpatient mental health services

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

- Individual and group mental health evaluation and treatment, including treatment of first episode psychosis
- Psychological testing when necessary to evaluate a Mental Health Condition
- Outpatient services for the purpose of monitoring drug therapy
- Behavioral Health Treatment for Autism Spectrum Disorder
- Electroconvulsive therapy
- Transcranial magnetic stimulation

Intensive psychiatric treatment programs

We cover intensive psychiatric treatment programs at a Plan Facility, such as:

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

Residential treatment

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

- Individual and group mental health evaluation and treatment
- Medical services
- Medication monitoring
- Room and board
- Social services
- Prescription Drugs prescribed by a Plan Provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Pharmacy Services" in this "Covered Benefits" section)
- Discharge planning

Gender-affirming services

For Covered Benefits you receive for treatment of gender dysphoria, as described in other parts of the "Covered Benefits" section, you will pay the Cost Share you would pay if the services were not related to gender dysphoria. For example:

- See "Administered Drugs and Products" for administered drugs
- See "Office Visits" for consultations for gender dysphoria treatment, such as hormone therapy, and hair removal procedures
- See "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services" for laboratory and imaging services
- See "Outpatient Pharmacy Services" for self-administered Prescription Drugs
- See "Reconstructive Surgery" for surgical services
- See "Rehabilitative and Habilitative Services" for speech (voice) therapy

Inpatient psychiatric hospitalization

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

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described under "Prior Authorization Procedure for Certain Referrals and Services" in the "How to Obtain Covered Benefits" section).

Additionally, we cover services provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services (collectively, "988 Services") for medically necessary treatment of a mental health or substance use disorder without prior authorization until the condition is stabilized, as required by state law. After the mental health or substance use disorder condition has been stabilized, post-stabilization care from Non-Plan Providers is subject to prior authorization as described under "Post-Stabilization Care" in the "Emergency Services and Care" section.

For these referral services and 988 Services, you pay the Cost Share required for services provided by a Plan Provider as described in this *EOC*.

For the following services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")
- Drugs administered by a mental health provider to treat a mental health condition (refer to "Administered Drugs and Products")
- Durable medical equipment (refer to "Durable Medical Equipment ('DME') for Home Use")
- Outpatient laboratory and sleep studies (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")
- Telehealth Visits (refer to "Telehealth Visits")

Office Visits

We cover the following:

- Primary Care Visits and Non-Physician Specialist Visits
- Physician Specialist Visits
- Group appointments
- Acupuncture services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain)
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside your Service Area when care can best be provided in your home as determined by a Plan Physician

For the following services, refer to these sections

- Abortion and abortion-related services (refer to "Reproductive Health Services")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")

Ostomy and Urological Supplies

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

- A Plan Physician has prescribed ostomy and urological supplies for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described under "Prior Authorization Procedure for Certain Referrals and Services" in the "How to Obtain Covered Benefits" section
- The services are provided inside your Service Area

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

Covered ostomy and urological supplies do not include the following services:

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services

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

- Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans
- Basic imaging services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds
- Nuclear medicine
- Routine retinal photography screenings
- Laboratory tests, including tests to monitor the effectiveness of dialysis and tests for specific genetic disorders for which genetic counseling is available
- Diagnostic services provided by Plan Providers who are not physicians (such as EKGs, EEGs, and sleep studies)
- Radiation therapy
- Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if (1) the equipment has been approved for you through the Plan's prior authorization process, as described under "Prior Authorization Procedure for Certain Referrals and Services" in the "How to Obtain Covered Benefits" section and (2) the equipment is provided inside your Service Area. (Coverage for ultraviolet light therapy equipment is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.)

We cover laboratory tests to diagnose or screen for COVID-19 from Plan Providers or Non-Plan Providers, including a provider visit for purposes of receiving the laboratory test.

We cover up to a total of eight FDA-authorized over-the-counter COVID-19 tests per calendar month from Plan Providers or Non-Plan Providers. Over-the-counter tests are self-administered tests that deliver results at home and are available without a prescription.

Covered outpatient imaging, laboratory, and other diagnostic and treatment services do not include the following services:

- Ultraviolet light therapy comfort, convenience, or luxury equipment or features

- Repair or replacement of ultraviolet light therapy equipment due to loss, theft, or misuse

For the following services, refer to these sections

- Abortion and abortion-related services (refer to "Reproductive Health Services")
- Fertility preservation services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Fertility Services (refer to "Fertility Services")
- Outpatient imaging and laboratory services that are Preventive Services, such as routine mammograms, bone density scans, and laboratory screening tests (refer to "Preventive Services")
- Outpatient procedures that include imaging and diagnostic services (refer to "Outpatient Surgery and Outpatient Procedures")

Outpatient Pharmacy Services

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

- Items prescribed by Plan Providers, within the scope of their licensure and practice
- Items prescribed by the following Non–Plan Providers:
  - Dentists if the drug is for dental care
  - Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Prior Authorization Procedure for Certain Referrals and Services" in the "How to Obtain Covered Benefits" section) and the Prescription Drug, supply, or supplement is covered as part of that referral
  - Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services and Care, Post-Stabilization Care, or Out-of-Area Urgent Care (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described in the "Post-Service Claims and Appeals" section)
  - Non–Plan Providers that are not providers of Emergency Services and Care or Out-of-Area Urgent Care if the prescription is for COVID-19 therapeutics (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described in the "Post-Service Claims and Appeals" section)

Note: If you obtain a prescription from a Non-Plan Provider related to dental care or for COVID-19 therapeutics as described above, we do not cover an office visit or any other services from the Non-Plan Provider.

How to obtain covered items

You must obtain covered items at a Plan Pharmacy or through our mail-order service unless you obtain the item from a Non-Plan Provider as part of covered Emergency Services and Care, Post-Stabilization Care, or Out-of-Area Urgent Care or a Non-Plan Provider prescribes COVID-19 therapeutics for you.

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

Refills

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

Day supply limit

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

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

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

The pharmacy may reduce the day supply dispensed at the Cost Share specified in the "Outpatient pharmacy services" section of the "Cost Share Summary" for any Prescription Drug to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific Prescription Drugs (your Plan Pharmacy can tell you if a drug you take is one of these drugs).

About the drug formulary

The drug formulary includes a list of Prescription Drugs that our Pharmacy and Therapeutics Committee has approved for our Members. Our Pharmacy and Therapeutics Committee, which is primarily composed of Plan Physicians and pharmacists, selects Prescription Drugs for the drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature. The drug formulary is updated monthly based on new information or new Prescription Drugs that become available. To find out which Prescription Drugs are on the drug formulary for your plan, refer to the California Commercial HMO formulary on our website at **kp.org/formulary**. The drug formulary also discloses requirements or limitations that apply to specific Prescription Drugs, such as whether there is a limit on the amount of the Prescription Drug that can be dispensed and whether the Prescription Drug must be obtained at certain specialty pharmacies. If you would like to request a copy of this drug formulary, call Member Services. Note: The presence of a Prescription Drug on the drug formulary does not necessarily mean that it will be prescribed for a particular medical condition.

Formulary exception process

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

Continuity drugs

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

About drug tiers

Prescription Drugs for your plan are categorized into tiers as described in the table below (your plan doesn't have a Tier 3). Your Cost Share for covered items may vary based on the tier. Refer to "Outpatient pharmacy services" in the "Cost Share Summary" section of this *EOC* for Cost Share for items covered under this section. Refer to the drug formulary to find out which tier a particular Prescription Drug is on and for the definition of "generic drug," "brand-name drug," and "specialty drug."

Tier	Description
Tier 1	Most generic Prescription Drugs, supplies, and supplements (also includes certain brand-name Prescription Drugs, supplies, and supplements)
Tier 2	Most brand-name Prescription Drugs, supplies, and supplements (also includes certain generic Prescription Drugs, supplies, and supplements)
Tier 4	High-cost brand-name or generic Prescription Drugs, supplies, and supplements (sometimes called "specialty drugs")

These tiers apply to formulary and non-formulary Prescription Drugs, supplies, and supplements. If you need help determining whether a formulary or non-formulary Prescription Drug, supply, or supplement is categorized as Tier 1, Tier 2, or Tier 4, call Member Services.

Note:

- Non-formulary Prescription Drugs are not covered unless Medically Necessary as described under "Formulary exception process" in the "About the drug formulary" section above
- Over-the-counter preventive drugs are not listed in the drug formulary (refer to "Preventive Services" for information about coverage for Preventive Services)

General rules about coverage and your Cost Share

Prescription Drugs, supplies, and supplements

We cover Prescription Drugs, supplies, and supplements listed under "Outpatient pharmacy services" in the "Cost Share Summary" section in accord with the requirements in this "Outpatient Pharmacy Services" section:

- Drugs for which a prescription is required by law
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs

We cover over-the-counter drugs, supplies, and supplements listed on our drug formulary or the Preventive Services list at **kp.org/prevention**, except that a prescription is not required for over-the counter contraceptives.

Note:

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

Schedule II drugs

You or the prescribing provider can request that the pharmacy dispense less than the prescribed amount of a covered oral, solid dosage form of a Schedule II drug (your Plan Pharmacy can tell you if a drug you take is one of these drugs). Your Cost Share will be prorated based on the amount of the drug that is dispensed. If the pharmacy does not prorate your Cost Share, we will send you a refund for the difference.

Mail-order service

Prescription refills can be mailed within 3 to 5 days at no extra cost for standard U.S. postage. The appropriate Cost Share (according to your drug coverage) will apply and must be charged to a valid credit card.

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

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

Note: Restrictions and limitations apply. For example, not all drugs can be mailed and we cannot mail drugs to all states.

Manufacturer coupon program

For Prescription Drugs or items that are covered under this "Outpatient Pharmacy Services" section and obtained at a Plan Pharmacy, you may be able to use approved manufacturer coupons as payment for the Cost Share that you owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon does not cover the entire amount of your Cost Share for your prescription. When you use an approved coupon for payment of your Cost Share, the coupon amount and any additional payment that you make will accumulate to your out-of-pocket maximum if applicable. Refer to the "Cost Share Summary" section of this *EOC* to find your applicable out-of-pocket maximum amount and to learn which drugs and items apply to the maximum. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at **kp.org/rxcoupons**.

Base drugs, supplies, and supplements

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

- Certain drugs for the treatment of life-threatening ventricular arrhythmia
- Drugs for the treatment of tuberculosis
- Elemental dietary enteral formula when used as a primary therapy for regional enteritis
- Hematopoietic agents for dialysis

- Hematopoietic agents for the treatment of anemia in chronic renal insufficiency
- Human growth hormone for long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion
- Immunosuppressants and ganciclovir and ganciclovir prodrugs for the treatment of cytomegalovirus when prescribed in connection with a transplant
- Phosphate binders for dialysis patients for the treatment of hyperphosphatemia in end stage renal disease

Formulas and food

We cover the following outpatient formulas and food:

- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)
- Medically necessary pasteurized human milk when prescribed by a Plan Provider and obtained from a designated licensed tissue bank. The day supply dispensed may vary based on availability. You may have to pay for the human milk and file a claim for reimbursement. For information on how to file a claim, see "Initial Claims" in the "Post-Service Claims and Appeals" section
- Elemental dietary enteral formula as described under "Base drugs" in this "Outpatient Pharmacy Services" section
- Enteral formula as described under "Prosthetic and Orthotic Services" in this "Covered Benefits" section

For the following services, refer to these sections

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

Outpatient Surgery and Outpatient Procedures

We cover outpatient surgery and outpatient procedures (including imaging and diagnostic services) from Plan Providers in the following situations:

- The services are provided in a medical office (for example, in a medical office special procedure room, minor surgery room, or exam room)
- The services are provided in an outpatient surgery area (for example, in an outpatient or ambulatory surgery center or a same day surgery in a hospital operating room)

For the following services, refer to these sections

- Abortion-related procedures (refer to "Abortion and abortion-related services" under "Reproductive Health Services")
- Fertility preservation services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Fertility Services (refer to "Fertility Services")
- Outpatient procedures (including imaging and diagnostic services) that do not require a licensed staff member to monitor your vital signs (refer to the section that would otherwise apply for the procedure; for example, for radiology procedures that do not require a licensed staff member to monitor your vital signs, refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

Preventive Services

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

- Services recommended by the United States Preventive Services Task Force with rating of "A" or "B." The complete list of these services can be found at **uspreventiveservicestaskforce.org**
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. The complete list

of recommended immunizations can be found at **cdc.gov**

- Preventive services recommended by the Health Resources and Services Administration and incorporated into the Affordable Care Act. The complete list of these services can be found at **hrsa.gov/womens-guidelines**

Note: We cover immunizations to prevent COVID-19 that are administered in a Plan Medical Office or by a Non-Plan Provider. If you obtain this immunization from a Non-Plan Provider (except for providers of Emergency Services and Care or Out-of-Area Urgent Care), we do not cover an office visit or any other services from the Non-Plan Provider other than administration of the vaccine.

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

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

Note: Preventive Services help you stay healthy, before you have symptoms. If you have symptoms, you may need other care, such as diagnostic or treatment services. If you receive any other Covered Benefits that are not Preventive Services before, during, or after a visit that includes Preventive Services, you will pay the applicable Cost Share for those other services. For example, if laboratory tests or imaging services ordered during a preventive office visit are not Preventive Services, you will pay the applicable Cost Share for those services.

For the following services, refer to these sections

- Family planning counseling, consultations, and sterilization services (refer to "Reproductive Health Services")
- Health education programs (refer to "Health Education")
- Milk pumps and lactation supplies (refer to "Lactation supplies" under "Durable Medical Equipment ("DME") for Home Use")
- Prescription Drugs that are Preventive Services (refer to "Outpatient Pharmacy Services")

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices coverage rules

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

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select
- The item has been approved for you through the Plan's prior authorization process, as described under "Prior Authorization Procedure for Certain Referrals and Services" in the "How to Obtain Covered Benefits" section
- The services are provided inside your Service Area

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

Covered prosthetic and orthotic devices do not include the following services:

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

Base prosthetic and orthotic devices

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

Internally implanted devices

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

For internally implanted prosthetic and orthotic devices, you pay the Cost Share for the procedure to implant the device. For example, see "Outpatient Surgery and Outpatient Procedures" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for Outpatient Surgery.

External devices

We cover the following external prosthetic and orthotic devices:

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

Supplemental prosthetic and orthotic devices

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

- Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
- Rigid and semi-rigid orthotic devices required to support or correct a defective body part
- Covered special footwear when custom made for foot disfigurement due to disease, injury, or developmental disability

For the following services, refer to these sections

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

Reconstructive Surgery

We cover the following reconstructive surgery services:

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

Covered reconstructive surgery does not include the following services:

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

For Covered Benefits related to reconstructive surgery that you receive, you will pay the Cost Share you would pay if the services were not related to reconstructive surgery. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient services,

and see “Outpatient surgery and outpatient procedures” in the “Cost Share Summary” for the Cost Share that applies for outpatient surgery.

For the following services, refer to these sections

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

Rehabilitative and Habilitative Services

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

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

We cover the following services:

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

Covered rehabilitative and habilitative services do not include the following services:

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

For the following services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder (refer to “Mental Health Services”)
- Durable medical equipment (refer to “Durable Medical Equipment (“DME”) for Home Use”)
- Home health care (refer to “Home Health Care”)
- Office visits that are not physical, occupational, and speech therapy visits (refer to “Office Visits”)
- Ostomy and urological supplies (refer to “Ostomy and Urological Supplies”)
- Physical, occupational, and speech therapy provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to “Hospital Inpatient Services” and “Skilled Nursing Facility Care”)
- Prosthetic and orthotic devices (refer to “Prosthetic and Orthotic Devices”)

Reproductive Health Services

Family planning services

We cover the following services when provided for family planning purposes:

- Family planning counseling
- Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices (“IUDs”) and office visits related to their insertion, removal, and management when provided to prevent pregnancy
- Sterilization procedures for Members assigned female at birth
- Sterilization procedures for Members assigned male at birth

Plan Doula services

If you are pregnant or were pregnant within the last 12 months and want Plan Doula services, talk to your care team. We cover the following Plan Doula services before, during, or after childbirth, miscarriage, stillbirth, and abortion:

- One initial visit (up to 90 minutes)
- Up to eight visits that may be provided in any combination of prenatal and postpartum visits (up to 60 minutes each)
- Support during labor and delivery

Up to two additional postpartum visits may be available (up to 180 minutes each).

Members must select a Plan Doula from our Doula Services directory. To learn how to find a doula or to view the Doula Services directory, visit **kp.org/doulacare**.

Covered Plan Doula services do not include the following services:

- Clinical or medical services (such as taking blood pressure or temperature, fetal heart tone checks, vaginal examinations, or postpartum clinical care)
- Assistance with activities of daily living
- Alternative or complementary modalities (such as aromatherapy, childbirth education, massage therapy, or placenta encapsulation)
- Yoga
- Birthing ceremonies
- Over-the-counter supplies or drugs
- Home birth
- Belly binding (traditional or ceremonial)
- Massage (maternal or infant)
- Photography
- Placenta encapsulation
- Vaginal steams
- Group classes on baby wearing

Abortion and abortion-related services

We cover the following services:

- Surgical abortion
- Prescription Drugs, in accord with our drug formulary guidelines
- Abortion-related services

For the following services, refer to these sections

- Fertility preservation services for iatrogenic Infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Fertility Services (refer to "Fertility Services")
- Office visits related to injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") when provided for medical reasons other than to prevent pregnancy (refer to "Office Visits")
- Outpatient administered drugs that are not contraceptives (refer to "Administered Drugs and Products")
- Outpatient laboratory and imaging services associated with family planning services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient contraceptive drugs and devices (refer to "Outpatient Pharmacy Services")
- Outpatient surgery and outpatient procedures when provided for medical reasons other than to prevent pregnancy (refer to "Outpatient Surgery and Outpatient Procedures")

Services in Connection with a Clinical Trial

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

- We would have covered the services if they were not related to a clinical trial
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other Life-Threatening condition, as determined in one of the following ways:
  - a Plan Provider makes this determination
  - you provide us with medical and scientific information establishing this determination
- If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live
- The clinical trial is an Approved Clinical Trial

For Covered Benefits related to a clinical trial, you will pay the Cost Share you would pay if the services were not related to a clinical trial. For example, see "Hospital inpatient Services" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient services.

Skilled Nursing Facility Care

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

We cover the following services:

- Physician and nursing services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment if Skilled Nursing Facilities ordinarily furnish the equipment (refer to "Prior Authorization Procedure for Certain Referrals and Services" in the "How to Obtain Covered Benefits" section)
- Imaging and laboratory services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Whole blood, red blood cells, plasma, platelets, and their administration
- Medical supplies
- Behavioral Health Treatment for Autism Spectrum Disorder
- Physical, occupational, and speech therapy
- Respiratory therapy

For the following services, refer to these sections

- Outpatient imaging, laboratory, and other diagnostic and treatment services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient physical, occupational, and speech therapy (refer to "Rehabilitative and Habilitative Services")

Substance Use Disorder Treatment

We cover services specified in this "Substance Use Disorder Treatment" section only when the services are for the prevention, diagnosis, or treatment of Substance Use Disorders. A "Substance Use Disorder" is a substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Outpatient substance use disorder treatment

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

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

We also cover methadone maintenance treatment at a licensed treatment center.

Residential treatment

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

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

Inpatient detoxification

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician services, drugs, dependency recovery services, education, and counseling.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described under "Prior Authorization Procedure for Certain Referrals and Services" in the "How to Obtain Covered Benefits" section).

Additionally, we cover services provided by a 988 center, mobile crisis team, or other provider of behavioral health crisis services (collectively, "988 Services") for medically necessary treatment of a mental health or substance use disorder without prior authorization until the condition is stabilized, as required by state law. After the mental health or substance use disorder condition has been stabilized, post-stabilization care from Non-Plan Providers is subject to prior authorization as described under "Post-Stabilization Care" in the "Emergency Services and Care" section.

For these referral services and 988 Services, you pay the Cost Share required for services provided by a Plan Provider as described in this *EOC*.

For the following services, refer to these sections

- Drugs administered by a substance use disorder treatment provider to treat a substance use disorder (refer to "Administered Drugs and Products")
- Outpatient laboratory, including drug testing (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient self-administered drugs (refer to "Outpatient Pharmacy Services")
- Telehealth Visits (refer to "Telehealth Visits")

Telehealth Visits

Telehealth Visits are intended to make it more convenient for you to receive Covered Benefits, when a Plan Provider determines it is medically appropriate for your medical condition. You may receive Covered Benefits via Telehealth Visits, when available and if the services would have been covered under this *EOC* if provided in person. You are not required to use Telehealth Visits, and you may choose to receive in-person services from a Plan Provider instead. Some Plan Providers offer services exclusively through a telehealth technology platform and have no physical location at which you can receive services. If you receive Covered Benefits from these Plan Providers, you may access your medical record of the Telehealth Visit and, unless you object, such information will be added to your Health Plan electronic medical record and shared with your Primary Care Physician.

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

- Interactive video visits
- Scheduled telephone visits

Transplant Services

We cover transplants of organs, tissue, or bone marrow if the Medical Group provides a written referral for care to a transplant facility. Health Plan prior authorization may be required. See "Prior Authorization Procedure for Certain Referrals and Services" in the "How to Obtain Covered Benefits" section for more details.

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

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover services you receive before that determination is made
- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for services for living transplant donors, we provide certain donation-related services for a donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These services must be directly related to a covered transplant for you, which may include certain services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Call Member Services for questions about donor services

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

For the following services, refer to these sections

- Dental services that are Medically Necessary to prepare for a transplant (refer to "Dental and Orthodontic Services")
- Outpatient imaging and laboratory services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")

Vision Services for Adult Members

For the purpose of this "Vision Services for Adult Members" section, an "Adult Member" is a Member who is age 19 or older and is not a Pediatric Member, as defined under "Vision Services for Pediatric Members" in this "Covered Benefits" section. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1.

We cover the following for Adult Members:

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

Optical services

We cover the services described in this "Optical services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this "Vision Services for Adult Members" section). Also, covered optical services do not include the following services:

- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices
- Items and services to reshape the eye or correct refractive defects of the eye

Special contact lenses

We cover the following:

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

Low vision devices

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

For the following services, refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than services covered under this "Vision Services for Adult Members" section, such as outpatient surgery and Prescription Drugs (refer to the applicable heading in this "Covered Benefits" section)

Vision Services for Pediatric Members

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

We cover the following for Pediatric Members:

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

Optical services

We cover the services described in this "Optical services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this "Vision Services for Pediatric Members" section). Also, covered optical services do not include the following services:

- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices
- Items and services to reshape the eye or correct refractive defects of the eye

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye

(including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

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

Low vision devices

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

For the following services, refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than services covered under this "Vision Services for Pediatric Members" section, such as outpatient surgery and Prescription Drugs (refer to the applicable heading in this "Covered Benefits" section)

Exclusions, Limitations, Coordination of Benefits, and Reductions

This Kaiser Permanente Traditional HMO Plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this *EOC*.

These exclusions and limitations do not apply to Medically Necessary basic health care services required to be covered under California or federal law, including but not limited to Medically Necessary treatment of a Mental Health or Substance Use Disorder, as well as preventive services required to be covered under California or federal law.

These exclusions and limitations do not apply when covered by this Kaiser Permanente Traditional HMO Plan or required by law.

Exclusions and Limitations

Acupuncture services

This Kaiser Permanente Traditional HMO Plan does not cover acupuncture services, except as described in this *EOC* under "Office Visits" in the "Covered Benefits" section, or as required by law, unless you have coverage for supplemental acupuncture services as described in an amendment to this *EOC*.

Chiropractic services

This Kaiser Permanente Traditional HMO Plan does not cover chiropractic services, except as required by law, unless you have coverage for supplemental chiropractic services as described in an amendment to this *EOC*.

Clinical trials

This Kaiser Permanente Traditional HMO Plan does not cover clinical trials, except Approved Clinical Trials as described in this *EOC* under "Services in Connection with a Clinical Trial" in the "Covered Benefits" section, or as required by law.

Coverage of Approved Clinical Trials does not include the following:

- The investigational drug, item, or service itself
- Drugs, items, devices, and services provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the Member
- Drugs, items, devices, and services specifically excluded from coverage in this *EOC*, except for drugs, items, devices, and services required to be covered pursuant to state and federal law
- Drugs, items, devices, and services customarily provided free of charge to a clinical trial participant by the research sponsor

This exclusion does not limit, prohibit, or modify a Member's rights to the Experimental Services or Investigational Services independent review process as described in this *EOC* under "Experimental Services or Investigational Services" in this "Exclusion" section, or to Independent Medical Review (IMR) from the Department of Managed Health Care (DMHC) as described in this *EOC* under "Independent Medical Review ('IMR') in the "Dispute Resolution" section.

Cosmetic services

This Kaiser Permanente Traditional HMO Plan does not cover cosmetic services, supplies, or surgeries that slow down or reverse the effects of aging, or alter or reshape normal structures of the body in order to improve appearance rather than function, except as required by law.

This Kaiser Permanente Traditional HMO Plan does not cover any services, supplies, or surgeries for the promotion, prevention, or other treatment of hair loss or hair growth, except as required by law.

This cosmetic services exclusion does not apply to the following:

- Medically Necessary treatment of complications resulting from cosmetic surgery, such as infections or hemorrhages, as described in the "Covered Benefits" section
- Reconstructive surgery as described in this *EOC* under "Reconstructive Surgery" in the "Covered Benefits" section
- For gender dysphoria, reconstructive surgery of primary and secondary sex characteristics to improve function, or create a normal appearance to the extent possible, for the gender with which a Member identifies, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery who are competent to evaluate the specific clinical issues involved in the care requested as described in this *EOC* under "Reconstructive Surgery" in the "Covered Benefits" section
- Testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after removal of all or part of a breast, and prostheses to replace all or part of an external facial body part as described in this *EOC* under "Prosthetic and Orthotic Devices" in the "Covered Benefits" section

Custodial or domiciliary care

This Kaiser Permanente Traditional HMO Plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, or domiciliary care, which involves a supervised living arrangement in a home-like environment for adults who are unable to live alone because of age-related impairments or physical, mental, or visual disabilities, except as required by law.

This exclusion does not apply to the following:

- Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals (see "Hospice Care" and "Home Health Care" in the "Covered Benefits" section)
- Assistance with activities of daily living that is provided as part of covered hospice, home health, skilled nursing facility services, inpatient hospital care, or services provided in a healthcare facility, including Mental Health or Substance Use Disorder services (see "Hospice Care," "Home Health Care," "Skilled Nursing Facility Care," "Hospital Inpatient Services," "Mental Health Services," and "Substance Using Disorder Treatment" in the "Covered Benefits" section)

Dental services

This Kaiser Permanente Traditional HMO Plan does not cover dental services or supplies, except as described in this *EOC* under "Dental and Orthodontic Services" and "Injury to Teeth" in the "Covered Benefits" section, or as required by law.

Dietary or nutritional supplements

This Kaiser Permanente Traditional HMO Plan does not cover dietary or nutritional supplements, except as described under "Outpatient Pharmacy Services" or "Preventive Services" in the "Covered Benefits" section or as required by law.

Disposable supplies for home use

This Kaiser Permanente Traditional HMO Plan does not cover disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, diapers, and incontinence supplies, except as described in this *EOC* under "Durable Medical Equipment ('DME') for Home Use," "Home Health Care," "Hospice Care," "Ostomy and Urological Supplies," and "Outpatient Pharmacy Services" in the "Covered Benefits" section, or as required by law.

Experimental Services or Investigational Services

This Kaiser Permanente Traditional HMO Plan does not cover Experimental Services or Investigational Services, except as described below, or as required by law.

"Experimental Services" are drugs, equipment, procedures or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental Services are not undergoing a clinical investigation.

"Investigational Services" are those drugs, equipment, procedures or services for which laboratory and/or animal studies have been completed and for which human studies are in progress but:

- Testing is not complete; and
- The efficacy and safety of such services in human subjects are not yet established; and
- The service is not in wide usage

The determination that a service is an Experimental Service or Investigational Service is based on:

- Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal

Regulations, Chapter I (Food and Drug Administration)

- Consultation with provider organizations, academic and professional specialists pertinent to the specific service
- Reference to current medical literature

However, if the health plan denies or delays coverage for your requested service on the basis that it is an Experimental Service or Investigational Service and you meet all the qualifications set out below, the health plan must provide an external, independent review.

Qualifications

- You must have a Life-Threatening or Seriously Debilitating condition
- Your Health Care Provider must certify to the health plan that you have a Life-Threatening or Seriously Debilitating condition for which standard therapies have not been effective in improving your condition, or are otherwise medically inappropriate, or there is no more beneficial standard therapy covered by the health plan
- Either (a) your Health Care Provider, who has a contract with or is employed by the health plan, has recommended a drug, device, procedure, or other therapy that the Health Care Provider certifies in writing is likely to be more beneficial to you than any available standard therapies, or (b) you or your Health Care Provider, who is a licensed, board-certified, or board-eligible physician qualified to practice in the area of practice appropriate to treat your condition, has requested a therapy that, based on two documents from acceptable medical and scientific evidence, is likely to be more beneficial for you than any available standard therapy
- You have been denied coverage by the health plan for the recommended or requested service
- If not for the health plan's determination that the recommended or requested service is an Experimental Service or Investigational Service, it would be covered

External, Independent Review Process

If the health plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the health plan will notify you within five business days of its decision and your opportunity to request external review of the health plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the health plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

DMHC's Independent Medical Review ("IMR")

This exclusion does not limit, prohibit, or modify a Member's rights to an IMR from the DMHC as described in this *EOC* in the "Dispute Resolution" section. In certain circumstances, you do not have to participate in the health plan's grievance or appeals process before requesting an IMR of denials for Experimental Services or Investigational Services. In such cases you may immediately contact the DMHC to request an IMR of this denial as described in this *EOC* in the "Dispute Resolution" section.

Hearing aids

This Kaiser Permanente Traditional HMO Plan does not cover hearing aids, except as described in this *EOC* under "Hearing Services" in the "Covered Benefits" section, or as required by law.

Non-licensed or non-certified providers

This Kaiser Permanente Traditional HMO Plan does not cover treatments or services rendered by a non-licensed or non-certified provider, except doula services as described in this *EOC* under "Reproductive Health Services" in the "Covered Benefits" section, or as required by law.

This exclusion also does not apply to Medically Necessary treatment of a Mental Health or Substance Use Disorder furnished or delivered by, or under the direction of, a Health Care Provider acting within the scope of practice of the provider's license or certification under applicable state law.

Personal or comfort items

This Kaiser Permanente Traditional HMO Plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.

Prescription Drugs / Outpatient Prescription Drugs

This Kaiser Permanente Traditional HMO Plan does not cover the following Prescription Drugs, except as described in this *EOC* under "Outpatient Pharmacy Services" or "Preventive Services" in the "Covered Benefits" section or as required by law:

- When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely

prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function

- When prescribed solely for the treatment of hair loss, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. The exclusion does not apply to drugs for mental performance when they are Medically Necessary to treat diagnosed mental illness or medical conditions affecting memory, including, but not limited to, treatment of the conditions or symptoms of dementia or Alzheimer's disease
- When prescribed solely for the purpose of losing weight, except when Medically Necessary for the treatment of Class III or severe obesity. We may require Members who are prescribed drugs for Class III or severe obesity to be enrolled in a covered comprehensive weight loss program, for a reasonable period of time prior to or concurrent with receiving the Prescription Drug
- When prescribed solely for the purpose of shortening the duration of the common cold
- Prescription Drugs available over the counter or for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the Prescription Drug). This exclusion does not apply to any of the following:
  - ♦ insulin
  - ♦ over-the-counter drugs as covered under preventive services, for example, over-the-counter FDA-approved contraceptive drugs
  - ♦ over-the-counter drugs for reversal of an opioid overdose
  - ♦ an entire class of Prescription Drugs when one drug within that class becomes available over the counter
- Replacement of lost or stolen drugs
- Drugs when prescribed by non-contracting providers for non-covered procedures and which are not authorized by a health plan or a Plan Provider, except when coverage is otherwise required in the context of Emergency Services and Care

Private duty nursing

This Kaiser Permanente Traditional HMO Plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as required by law.

Reversal of voluntary sterilization

This Kaiser Permanente Traditional HMO Plan does not cover reversal of voluntary sterilization, except for Medically Necessary treatment of medical complications as described in the "Covered Benefits" section, except as required by law.

Routine physical examination

This Kaiser Permanente Traditional HMO Plan does not cover physical examinations for the sole purpose of travel, insurance, licensing, employment, school, camp, court-ordered examinations, or other non-preventive purpose, except as required by law.

Surrogate pregnancy

This Kaiser Permanente Traditional HMO Plan does not cover testing, services, or supplies for a person who is not covered under this *EOC* for a surrogate pregnancy, except as required by law.

Therapies

This Kaiser Permanente Traditional HMO Plan does not cover the following physical and occupational therapies, except as described in this *EOC* under "Rehabilitative and Habilitative Services" in the "Covered Benefits" section, or as required by law:

- Massage therapy, unless it is a component of a treatment plan
- Training or therapy for the treatment of learning disabilities or behavioral problems
- Social skills training or therapy
- Vocational, educational, recreational, art, dance, music, or reading therapy

Travel and lodging

This Kaiser Permanente Traditional HMO Plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in this *EOC* under "Ambulance Services" in the "Covered Benefits" section, as described under "Travel and Lodging for Certain Services" in the 'How to Obtain Covered Benefits" section, or as required by law.

Vision care

This Kaiser Permanente Traditional HMO Plan does not cover vision services, except as described in this *EOC* under "Vision Services for Adult Members" and "Vision Services for Pediatric Members" in the "Covered Benefits" section, or as required by law.

Weight control programs and exercise programs

This Kaiser Permanente Traditional HMO Plan does not cover weight control programs and exercise programs, except as described in this *EOC* under "Health Education" in the "Covered Benefits" section, or as required by law.

Coordination of Benefits

The services covered under this *EOC* are subject to coordination of benefits rules.

Coverage other than Medicare coverage

If you have medical or dental coverage under another plan that is subject to coordination of benefits, we will coordinate benefits with the other coverage under the coordination of benefits rules of the California Department of Managed Health Care. Those rules are incorporated into this *EOC*.

If both the other coverage and we cover the same Service, the other coverage and we will see that up to 100 percent of your covered medical expenses are paid for that Service. The coordination of benefits rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary coverage. You must give us any information we request to help us coordinate benefits.

If your coverage under this *EOC* is secondary, we may be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during a calendar year to pay for your out-of-pocket expenses for services that are partially covered by either your other coverage or us during that calendar year. If you are entitled to a Benefit Reserve Account, we will provide you with detailed information about this account.

If you have any questions about coordination of benefits, call Member Services.

Medicare coverage

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

Reductions

Employer responsibility

For any services that the law requires an employer to provide, we will not pay the employer, and when we cover any such services we may recover the value of the services from the employer.

Government agency responsibility

For any services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and when we cover any such services we may recover the value of the services from the government agency.

Injuries or illnesses alleged to be caused by other parties

If you obtain a judgment or settlement from or on behalf of another party who allegedly caused an injury or illness for which you received Covered Benefits, you must reimburse us to the maximum extent allowed under California Civil Code Section 3040. The reimbursement due to us is not limited by or subject to the Plan Out-of-Pocket Maximum. Note: This "Injuries or illnesses alleged to be caused by other parties" section does not affect your obligation to pay your Cost Share for these services.

To the extent permitted or required by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another 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 other party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain (1) against another party, and/or (2) from other types of coverage or sources of payment that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, workers' compensation, and/or personal injury coverages, any other types of medical payments and all other first party types of coverages or sources of payment. The proceeds of any judgment or settlement that you or we obtain and/or payments that you receive shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred.

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

The Rawlings Company
One Eden Parkway
P.O. Box 2000

LaGrange, KY 40031-2000
Fax: 502-753-7064
Email:
ManualFileCoordinator@rawlingscompany.com

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

If your estate, parent, guardian, or conservator asserts a claim against another 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 other party. We may assign our rights to enforce our liens and other rights.

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

Assisted Reproduction Agreement (pending regulatory approval)

If you enter into an Assisted Reproduction Agreement and you or any other payee are entitled to receive monetary compensation under the Assisted Reproduction Agreement, you must reimburse us for Covered Benefits including Fertility Services you receive in connection with that agreement to the maximum extent allowed under California Civil Code Section 3040. Note: This "Assisted Reproduction Agreement" section does not affect your obligation to pay your Cost Share for these services. If you are a surrogate, and you surrender a baby to the legal parents, you are not obligated to reimburse us for any services that the baby receives (the legal parents are financially responsible for any services that the baby receives).

By entering into an Assisted Reproduction Agreement, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Assisted Reproduction Agreement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into an Assisted Reproduction Agreement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and phone numbers of the other parties to the arrangement
- Names, addresses, and phone numbers of any escrow agent or trustee
- Names, addresses, and phone numbers of the Intended Parents and any other parties who are financially responsible for Fertility Services and/or services the baby or babies receive, including names, addresses, and phone numbers for any health insurance, Intended Parent(s), third-party donors, and/or Gestational Carriers
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

The Rawlings Company
One Eden Parkway
P.O. Box 2000
LaGrange, KY 40031-2000
Fax: 502-753-7064
Email:
ManualFileCoordinator@rawlingscompany.com

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 "Assisted Reproduction Agreement" section and to satisfy those rights. You may not agree to waive, release, or reduce, or in any other manner, take action that may affect our rights under this "Assisted Reproduction Agreement" section without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against another party based on the Assisted Reproduction Agreement, 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 under applicable law as if you had asserted the claim against the other party. We may assign our rights to enforce our liens and other rights.

If you have questions about your obligations under this provision, call Member Services.

Note: A baby born under an Assisted Reproduction Agreement does not have health coverage rights under the surrogate's health coverage. The intended parents of a child born under an Assisted Reproduction Agreement will need to arrange for health coverage for the newborn.

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

If you suffer from an injury or illness that is compensable under a workers' compensation or employer's liability law, we will provide services related to the injury or illness ("Workers' Compensation Services") when obtained at a Kaiser facility. We will not cover any Workers' Compensation Services obtained from Non-Plan Providers. Any Workers' Compensation Services provided or paid for by Health Plan are subject to your obligation to reimburse us to the extent of a payment or any other benefit, including any amount received as a settlement that you receive under applicable law.

In addition, we or our Plan Providers will be permitted to seek reimbursement for these Workers' Compensation Services directly from the responsible employer or the government agency that administers applicable law.

Post-Service Claims and Appeals

This "Post-Service Claims and Appeals" section explains how to file a claim for payment or reimbursement for services that you have already received. Use the procedures in this section in the following situations:

- You have received Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance services, or COVID-19 testing, therapeutics, or immunization services from a Non–Plan Provider and you want us to pay for the services
- You have received services from a Non–Plan Provider that we did not authorize (other than Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance services, or COVID-19 testing, therapeutics, or immunization services) and you want us to pay for the services
- You want to appeal a denial of an initial claim for payment

Follow the procedures under "Grievances" in the "Dispute Resolution" section in the following situations:

- You want us to cover services that you have not yet received
- You want us to continue to cover an ongoing course of covered treatment
- You want to appeal a written denial of a request for services that require prior authorization (as described under "Prior Authorization Procedure for Certain Referrals and Services")

Who May File

The following people may file claims:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a claim for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the claim
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the claim
- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services office at a Plan Facility, on our website at **kp.org**, or by calling Member Services. Your written authorization must accompany the claim. You must pay the cost of anyone you hire to represent or help you.

Supporting Documents

You can request payment or reimbursement orally or in writing. Your request for payment or reimbursement, and

any related documents that you give us, constitute your claim.

Claim forms for Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance services, COVID-19 services, Plan Doula services, and human milk

To file a claim in writing for Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance services, or COVID-19 testing, therapeutics, or immunization services, use our claim form. You can obtain a claim form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

Claims forms for all other services

To file a claim in writing for all other services, you may use our grievance form. You can obtain this form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

Other supporting information

When you file a claim, include any information that clarifies or supports your position. For example, if you have paid for services, include any bills and receipts that support your claim. To request that we pay a Non–Plan Provider for services, include any bills from the Non–Plan Provider. If the Non–Plan Provider states that they will file the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. When appropriate, we will request medical records from Plan Providers on your behalf. If you tell us that you have consulted with a Non–Plan Provider and are unable to provide copies of relevant medical records, we will contact the provider to request a copy of your relevant medical records. We will ask you to provide us a written authorization so that we can request your records.

If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should follow the steps in the written notice sent to you about your claim.

Initial Claims

To request that we pay a provider (or reimburse you) for services that you have already received, you must file a claim. If you have any questions about the claims process, call Member Services.

Submitting a claim for Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance services, COVID-19 services, Plan Doula services, and human milk

You may file a claim (request for payment/reimbursement):

- By visiting **kp.org**, completing an electronic form and uploading supporting documentation;
- By mailing a paper form that can be obtained by visiting **kp.org** or calling Member Services; or
- If you are unable access the electronic form (or obtain the paper form), by mailing the minimum amount of information we need to process your claim:
  - Member/Patient Name and Medical/Health Record Number
  - The date you received the services
  - Where you received the services
  - Who provided the services
  - Why you think we should pay for the services
  - A copy of the bill, your medical record(s) for these services, and your receipt if you paid for the services

Mailing address to submit your claim to Kaiser Permanente:

Kaiser Permanente
Claims Administration - NCAL
P.O. Box 12923
Oakland, CA 94604-2923

Call Member Services if you need help filing your claim.

Submitting a claim for all other services

If you have received any other services from a Non–Plan Provider that we did not authorize, then as soon as possible after you receive the services, you must file your claim in one of the following ways:

- By delivering your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By mailing your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Call Member Services if you need help filing your claim.

After we receive your claim

We will send you an acknowledgment letter within five days after we receive your claim.

After we review your claim, we will respond as follows:

- If we have all the information we need, we will send you a written decision within 30 days after we receive your claim
- If we need more information, we will ask you for the information before the end of the initial 30-day decision period. We will send our written decision no later than 30 days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in our letter, we will make our decision based on the information we have within 30 days after the end of that timeframe

If we pay any part of your claim, we will subtract applicable Cost Share from any payment we make to you or the Non–Plan Provider. You are not responsible for any amounts beyond your Cost Share for covered Emergency Services and Care. If we deny your claim (if we do not agree to pay for all the services you requested other than the applicable Cost Share), our letter will explain why we denied your claim and how you can appeal.

If you later receive any bills from the Non–Plan Provider for Covered Benefits (other than bills for your Cost Share), call Member Services for assistance.

Appeals

Claims for Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance services, or COVID-19 services, Plan Doula services, or human milk from a Non–Plan Provider

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By mailing your appeal to the Claims Department at the following address:

  Kaiser Foundation Health Plan, Inc.
  Special Services Unit
  P.O. Box 23280
  Oakland, CA 94623
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Claims for all other services from a Non-Plan Provider that we did not authorize

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By visiting our website at **kp.org**
- By mailing your appeal to any Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- In person at any Member Services office at a Plan Facility or any Plan Provider (for addresses, refer to our Provider Directory or call Member Services)
- By calling Member Services at **1-800-464-4000** (TTY users call **711**)

When you file an appeal, include any information that clarifies or supports your position. If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Additional information regarding claims for all other services from a Non–Plan Provider that we did not authorize

If we initially denied your request, you must file your appeal within 180 days after the date you received our denial letter. You may send us information including comments, documents, and medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still

send us the additional information so that we may include it as part of our review of your appeal. Send all additional information to the address or fax mentioned in your denial letter.

Also, you may give testimony in writing or by phone. Send your written testimony to the address mentioned in our acknowledgment letter, sent to you within five days after we receive your appeal. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will review it without regard to whether this information was filed or considered in our initial decision regarding your request for services. You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our final decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

We will send you a resolution letter within 30 days after we receive your appeal. If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

External Review

You must exhaust our internal claims and appeals procedures before you may request external review unless we have failed to comply with the claims and appeals procedures described in this "Post-Service Claims and Appeals" section. For information about the external review process, see "Independent Medical Review ("IMR")" in the "Dispute Resolution" section.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-EBSA** (**1-866-444-3272**)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Dispute Resolution

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

Grievances

This "Grievances" section describes our grievance procedure. A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. If you want to make a claim for payment or reimbursement for services that you have already received from a Non–Plan Provider, follow the procedure in the "Post-Service Claims and Appeals" section.

Here are some examples of reasons you might file a grievance:

- You are not satisfied with the quality of care you received from a Plan Provider or a Non-Plan Provider to which you have been referred
- You received a written denial of services that require prior authorization and you want us to cover the services
- You received a written denial for a second opinion or we did not respond to your request for a second opinion in an expeditious manner, as appropriate for your condition
- Your treating physician has said that services are not Medically Necessary and you want us to cover the services
- You were told that services are not covered and you believe that the services should be covered

- You want us to continue to cover an ongoing course of covered treatment
- You are dissatisfied with how long it took to get services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility
- You believe you have faced discrimination from providers, staff, or Health Plan
- We terminated your membership and you disagree with that termination

Who may file

The following people may file a grievance:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a grievance for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the grievance
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the grievance
- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal
- Your physician may act as your authorized representative with your verbal consent to request an urgent grievance as described under "Urgent procedure" in this "Grievances" section

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services office at a Plan Facility, on our website at **kp.org**, or by calling Member Services. Your written authorization must accompany the grievance. You must pay the cost of anyone you hire to represent or help you.

How to file

You can file a grievance orally or in writing. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with the services you received.

Standard Procedure

To file a grievance electronically, use the grievance form on **kp.org**.

To file a grievance orally, call Member Services toll free at **1-800-464-4000** (TTY users call **711**).

To file a grievance in writing, use our grievance form, which is available on **kp.org** under "Forms & Publications," in person from any Member Services office at a Plan Facility, or from Plan Providers (for addresses, refer to our Provider Directory or call Member Services). You can submit the form in the following ways:

- In person at any Member Services office at a Plan Facility
- By mail to any Member Services office at a Plan Facility

You must file your grievance within 180 days following the incident or action that is subject to your dissatisfaction. You may send us information including comments, documents, and medical records that you believe support your grievance.

Call Member Services if you need help filing a grievance.

If your grievance involves a request to obtain a non-formulary Outpatient Prescription Drug, we will notify you of our decision within 72 hours. If we do not decide in your favor, our letter will explain why and describe your further appeal rights. For information on how to request a review by an independent review organization, see "Independent Review Organization for Non-Formulary Outpatient Prescription Drug Requests" in this "Dispute Resolution" section.

For all other grievances, we will send you an acknowledgment letter within five days after we receive your grievance. We will send you a resolution letter within 30 days after we receive your grievance. If you are requesting services, and we do not decide in your favor, our letter will explain why and describe your further appeal rights.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Urgent procedure

If you want us to consider your grievance on an urgent basis, tell us that when you file your grievance. Note: Urgent is sometimes referred to as "exigent." If exigent circumstances exist, your grievance may be reviewed using the urgent procedure described in this section.

You must file your urgent grievance in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 1809
  Pleasanton, CA 94566
- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By completing the grievance form on our website at **kp.org**

We will decide whether your grievance is urgent or non-urgent unless your attending Health Care Provider tells us your grievance is urgent. If we determine that your grievance is not urgent, we will use the procedure described under "Standard procedure" in this "Grievances" section. Generally, a grievance is urgent only if one of the following is true:

- Using the standard procedure could seriously jeopardize your life, health, or ability to regain maximum function
- Using the standard procedure would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment
- A physician with knowledge of your medical condition determines that your grievance is urgent
- You have received Emergency Services and Care but have not been discharged from a facility and your request involves admissions, continued stay, or other health care services
- You are undergoing a current course of treatment using a non-formulary Outpatient Prescription Drug and your grievance involves a request to refill a non-formulary Outpatient Prescription Drug

For most grievances that we respond to on an urgent basis, we will give you oral notice of our decision as soon as your clinical condition requires, but no later than 72 hours after we received your grievance. We will send you a written confirmation of our decision within three days after we received your grievance.

If your grievance involves a request to obtain a non-formulary Outpatient Prescription Drug and we respond to your request on an urgent basis, we will notify you of our decision within 24 hours of your request. For information on how to request a review by an independent review organization, see "Independent Review Organization for Non-Formulary Outpatient Prescription Drug Requests" in this "Dispute Resolution" section.

If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care at any time at **1-888-466-2219** (TDD **1-877-688-9891**) without first filing a grievance with us.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call Member Services.

Additional information regarding pre-service requests for Medically Necessary services

You may give testimony in writing or by phone. Send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your grievance file and we will consider it in our decision regarding your pre-service request for Medically Necessary services.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you

choose to do so. If your grievance is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your grievance file.

Additional information regarding appeals of written denials for services that require prior authorization
You must file your appeal within 180 days after the date you received our denial letter.

You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your appeal.

Also, you may give testimony in writing or by phone. Send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will consider it in our decision regarding your appeal.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your appeal is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

Additional information about utilization review determination criteria for mental health services or substance use disorder treatment
Utilization review determination criteria and any education program materials for individuals making authorization decisions related to mental health services or substance use disorder treatment are available at **kp.org** at no cost.

Independent Review Organization for Non-Formulary Outpatient Prescription Drug Requests

If you filed a grievance to obtain a non-formulary Outpatient Prescription Drug and we did not decide in your favor, you may submit a request for a review of your grievance by an independent review organization ("IRO"). You must submit your request for IRO review within 180 days of the receipt of our decision letter.

You must file your request for IRO review in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 1809
  Pleasanton, CA 94566
- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)
- By completing the grievance form on our website at **kp.org**

For urgent IRO reviews, we will forward to you the independent reviewer's decision within 24 hours. For non-urgent requests, we will forward the independent reviewer's decision to you within 72 hours. If the independent reviewer does not decide in your favor, you may submit a complaint to the Department of Managed Health Care, as described under "Department of Managed Health Care Complaints" in this "Dispute Resolution" section. You may also submit a request for an Independent Medical Review as described under "Independent Medical Review" in this "Dispute Resolution" section.

Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll free at **1-800-464-4000** (TTY users call **711**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may

be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review ("IMR")

Except as described in this "Independent Medical Review ("IMR")" section, you must exhaust our internal grievance procedure before you may request independent medical review unless we have failed to comply with the grievance procedure described under "Grievances" in this "Dispute Resolution" section. If you qualify, you or your authorized representative may have your issue reviewed through the IMR process managed by the California Department of Managed Health Care ("DMHC"). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against us.

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

- One of these situations applies to you:
  - ♦ you have a recommendation from a provider requesting Medically Necessary services
  - ♦ you have received emergency or urgent medical services from a provider who determined the services to be Medically Necessary
  - ♦ you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment or services has been denied, modified, or delayed based in whole or in part on a decision that the services are not Medically Necessary
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for urgent grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function. If we have denied your grievance, you must submit your request for an IMR within six months of the date of our written denial. However, the DMHC may accept your request after six months if they determine that circumstances prevented timely submission

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

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

Experimental or investigational denials

If we deny services because they are Experimental Services or Investigational Services, we will send you our written explanation within three days after we received your request. We will explain why we denied the services 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
- If your treating physician is a Plan Physician, they recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying their recommendation
- You (or your Non–Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the

physician in certifying their recommendation. We do not cover the services of the Non–Plan Provider

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

Office of Civil Rights Complaints

If you believe that you have been discriminated against by a Plan Provider or by us because of your race, color, national origin, disability, age, sex (including sex stereotyping and gender identity), or religion, you may file a complaint with the Office of Civil Rights in the United States Department of Health and Human Services ("OCR").

You may file your complaint with the OCR within 180 days of when you believe the act of discrimination occurred. However, the OCR may accept your request after six months if they determine that circumstances prevented timely submission. For more information on the OCR and how to file a complaint with the OCR, see the Notice of Nondiscrimination provided with this *EOC*.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at **1-866-444-EBSA** (**1-866-444-3272**)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Binding Arbitration

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

Scope of arbitration

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

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. ("Health Plan"), including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- Governing law does not prevent the use of binding arbitration to resolve the claim

Members enrolled under this *EOC* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

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

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

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

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC

- The Permanente Company, LLC
- Any Southern California Permanente Medical Group or The Permanente Medical Group physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties
- Any employee or agent of any of the foregoing

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

Rules of Procedure

Arbitrations shall be conducted according to the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure") developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from Member Services.

Initiating arbitration

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

Serving Demand for Arbitration

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

Kaiser Foundation Health Plan, Inc.
Legal Department, Professional & Public Liability
1 Kaiser Plaza, 19th Floor
Oakland, CA 94612

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

Filing fee

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

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling Member Services.

Number of arbitrators

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (see the Rules of Procedure).

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

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

Payment of arbitrators' fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the Rules of Procedure. In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

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

Costs

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

General provisions

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

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

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

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2028, your last minute of coverage was at 11:59 p.m. on December 31, 2027). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section.

Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, your Group will notify you of the date that your membership will end. Your membership termination date is the first day you are not covered. For example, if your termination date is January 1, 2028, your last minute of coverage was at 11:59 p.m. on December 31, 2027.

Termination of *Agreement*

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Termination for Cause

If you intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider, we may terminate your membership by sending written notice to the Subscriber; termination will be effective 30 days from the date we send the notice. Some examples of fraud include:

- Misrepresenting eligibility information about you or a Dependent
- Presenting an invalid prescription or physician order
- Misusing a Kaiser Permanente ID card (or letting someone else use it)

- Giving us incorrect or incomplete material information. For example, you have entered into an Assisted Reproduction Agreement and you fail to send us the information we require under "Assisted Reproduction Agreement" under "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section
- Failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits

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

Termination of a Product or all Products

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

Payments after Termination

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

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Dispute Resolution" section

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

State Review of Membership Termination

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

Continuation of Membership

If your membership under this *EOC* ends, you may be eligible to continue Health Plan membership without a break in coverage. You may be able to continue Group coverage under this *EOC* as described under "Continuation of Group Coverage." Also, you may be able to continue membership under an individual plan as described under "Continuation of Coverage under an Individual Plan." If at any time you become entitled to continuation of Group coverage, examine your coverage options carefully before declining this coverage. Individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

Continuation of Group Coverage

COBRA

You may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll you must submit a COBRA election form to your Group within the COBRA election period. Ask your Group for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

If you enroll in COBRA and exhaust the time limit for COBRA coverage, you may be able to continue Group coverage under state law as described under "Cal-COBRA" in this "Continuation of Group Coverage" section.

Cal-COBRA

If you are eligible for coverage under the California Continuation Benefits Replacement Act ("Cal-COBRA"), you can continue coverage as described in this "Cal-COBRA" section if you apply for coverage in compliance with Cal-COBRA law and pay applicable Premiums.

Eligibility and effective date of coverage for Cal-COBRA after COBRA

If your group is subject to COBRA and your COBRA coverage ends, you may be able to continue Group

coverage effective the date your COBRA coverage ends if all of the following are true:

- Your effective date of COBRA coverage was on or after January 1, 2003
- You have exhausted the time limit for COBRA coverage and that time limit was 18 or 29 months
- You do not have Medicare

You must request an enrollment application by calling Member Services within 60 days of the date of when your COBRA coverage ends.

Cal-COBRA enrollment and Premiums

Within 10 days of your request for an enrollment application, we will send you our application, which will include Premium and billing information. You must return your completed application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay Full Premiums within 45 days after the date we issue the bill. The first Premium payment will include coverage from your Cal-COBRA effective date through our current billing cycle. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

After that first payment, your Premium payment for the upcoming coverage month is due on the last day of the preceding month. The Premiums will not exceed 110 percent of the applicable Premiums charged to a similarly situated individual under the Group benefit plan except that Premiums for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent instead of 110 percent. Returned checks or insufficient funds on electronic payments may be subject to a fee.

If you have selected Ancillary Coverage provided under any other program, the Premium for that Ancillary Coverage will be billed together with required Premiums for coverage under this *EOC*. Full Premiums will then also include Premium for Ancillary Coverage. This means if you do not pay the Full Premiums owed by the due date, we may terminate your membership under this *EOC* and any Ancillary Coverage, as described in the "Termination for nonpayment of Cal-COBRA Premiums" section.

Changes to Cal-COBRA coverage and Premiums

Your Cal-COBRA coverage is the same as for any similarly situated individual under your Group's *Agreement*, and your Cal-COBRA coverage and Premiums will change at the same time that coverage or Premiums change in your Group's *Agreement*. Your Group's coverage and Premiums will change on the renewal date of its *Agreement* (January 1), and may also change at other times if your Group's *Agreement* is amended. Your monthly invoice will reflect the current Premiums that are due for Cal-COBRA coverage, including any changes. For example, if your Group makes a change that affects Premiums retroactively, the amount we bill you will be adjusted to reflect the retroactive adjustment in Premiums. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended. You can also request one from Member Services.

Cal-COBRA open enrollment or termination of another health plan

If you previously elected Cal-COBRA coverage through another health plan available through your Group, you may be eligible to enroll in Kaiser Permanente during your Group's annual open enrollment period, or if your Group terminates its agreement with the health plan you are enrolled in. You will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA. Ask your Group for information about health plans available to you either at open enrollment or if your Group terminates a health plan's agreement.

In order for you to switch from another health plan and continue your Cal-COBRA coverage with us, we must receive your enrollment application during your Group's open enrollment period, or within 63 days of receiving the Group's termination notice described under "Group responsibilities." To request an application, call Member Services. We will send you our enrollment application and you must return your completed application before open enrollment ends or within 63 days of receiving the termination notice described under "Group responsibilities." If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay the bill within 45 days after the date we issue the bill. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

How you may terminate your Cal-COBRA coverage

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

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

Termination for nonpayment of Cal-COBRA Premiums
If you do not pay Full Premiums by the due date, we may terminate your membership as described in this "Termination for nonpayment of Cal-COBRA Premiums" section. If you intend to terminate your membership, be sure to notify us as described under "How you may terminate your Cal-COBRA coverage" in this "Cal-COBRA" section, as you will be responsible for any Premiums billed to you unless you let us know before the first of the coverage month that you want us to terminate your coverage.

Your Premium payment for the upcoming coverage month is due on the last day of the preceding month. If we do not receive Full Premium payment by the due date, we will send a notice of nonreceipt of payment to the Subscriber's address of record. You will have a 30-day grace period to pay the required Premiums before we terminate your Cal-COBRA coverage for nonpayment. The notice will state when the grace period begins and when the memberships of the Subscriber and all Dependents will terminate if the required Premiums are not paid. Your coverage will continue during this grace period. If we do not receive Full Premium payment by the end of the grace period, we will mail a termination notice to the Subscriber's address of record. After termination of your membership for nonpayment of Cal-COBRA Premiums, you are still responsible for paying all amounts due, including Premiums for the grace period.

Reinstatement of your membership after termination for nonpayment of Cal-COBRA Premiums
If we terminate your membership for nonpayment of Premiums, we will permit reinstatement of your membership three times during any 12-month period if we receive the amounts owed within 15 days of the date of the Termination Notice. We will not reinstate your membership if you do not obtain reinstatement of your terminated membership within the required 15 days, or if we terminate your membership for nonpayment of Premiums more than three times in a 12-month period.

Termination of Cal-COBRA coverage
Cal-COBRA coverage continues only upon payment of applicable monthly Premiums to us at the time we specify, and terminates on the earliest of:

- The date your Group's *Agreement* with us terminates (you may still be eligible for Cal-COBRA through another Group health plan)
- The date you get Medicare
- The date your coverage begins under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have (or that does contain such an exclusion or limitation, but it has been satisfied)
- The date that is 36 months after your original COBRA effective date (under this or any other plan)
- The date your membership is terminated for nonpayment of Premiums as described under "Termination for nonpayment of Cal-COBRA Premiums" in this "Continuation of Membership" section

Note: If the Social Security Administration determined that you were disabled at any time during the first 60 days of COBRA coverage, you must notify your Group within 60 days of receiving the determination from Social Security. Also, if Social Security issues a final determination that you are no longer disabled in the 35th or 36th month of Group continuation coverage, your Cal-COBRA coverage will end the later of: (1) expiration of 36 months after your original COBRA effective date, or (2) the first day of the first month following 31 days after Social Security issued its final determination. You must notify us within 30 days after you receive Social Security's final determination that you are no longer disabled.

Group responsibilities
If your Group's agreement with a health plan is terminated, your Group is required to provide written notice at least 30 days before the termination date to the persons whose Cal-COBRA coverage is terminating. This notice must inform Cal-COBRA beneficiaries that they can continue Cal-COBRA coverage by enrolling in any health benefit plan offered by your Group. It must also include information about benefits, premiums, payment instructions, and enrollment forms (including instructions on how to continue Cal-COBRA coverage under the new health plan). Your Group is required to send this information to the person's last known address, as provided by the prior health plan. Health Plan is not obligated to provide this information to qualified beneficiaries if your Group fails to provide the notice. These persons will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA.

USERRA

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal Uniformed Services

Employment and Reemployment Rights Act ("USERRA"). You must submit a USERRA election form to your Group within 60 days after your call to active duty. Contact your Group to find out how to elect USERRA coverage and how much you must pay your Group.

Coverage for a Disabling Condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates and is not renewed, we will cover services for your totally disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's *Agreement* with us terminated
- You are no longer Totally Disabled
- Your Group's *Agreement* with us is replaced by another group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this *EOC,* including Cost Share, but we will not cover services for any condition other than your totally disabling condition.

For Subscribers and adult Dependents, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in any employment or occupation, even with training, education, and experience.

For Dependent children, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

To request continuation of coverage for your disabling condition, you must call Member Services within 30 days after your Group's *Agreement* with us terminates.

Continuation of Coverage under an Individual Plan

If you want to remain a Health Plan member when your Group coverage ends, you might be able to enroll in one of our Kaiser Permanente for Individuals and Families plans. The premiums and coverage under our individual plan coverage are different from those under this *EOC*.

If you want your individual plan coverage to be effective when your Group coverage ends, you must submit your application within the special enrollment period for enrolling in an individual plan due to loss of other coverage. Otherwise, you will have to wait until the next annual open enrollment period.

To request an application to enroll directly with us, go to **buykp.org** or call Member Services. For information about plans that are available through Covered California, see "Covered California" below.

Covered California

U.S. citizens or legal residents of the U.S. can buy health care coverage from Covered California. This is California's health benefit exchange ("the Exchange"). You may apply for help to pay for premiums and copayments but only if you buy coverage through Covered California. This financial assistance may be available if you meet certain income guidelines. To learn more about coverage that is available through Covered California, visit **CoveredCA.com** or call Covered California at **1-800-300-1506** (TTY users call **711**).

Miscellaneous Provisions

Administration of *Agreement*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of your Group's *Agreement,* including this *EOC*.

Advance Health Care Directives

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

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

chart, or you can put them in writing and have that included in your medical chart

For more information about Advance Health Care Directives, refer to our website at **kp.org**, call Member Services, or contact the California Attorney General's Office.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *EOC*, your Group is required to inform you in accord with applicable law and your Group's *Agreement*.

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *EOC*.

Assignment

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

Attorney and Advocate Fees and Expenses

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

Catastrophic Events

We will make a good faith effort to provide or arrange for Covered Benefits upon the occurrence of circumstances or an event not within Health Plan's reasonable control that delay or render impractical the provision of services under this *EOC*, such as a natural disaster (for example, earthquake, wildfire, hurricane or tornado), epidemic, pandemic, terrorism, war, riot, civil insurrection, government acts, changes in applicable law, disability of entities providing services to Health Plan, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor dispute ("Catastrophic Event") in order to minimize the effects of the Catastrophic Event taking into account its impact on the provision of Covered Benefits. Such effort may include reasonably and prudently processing requests for Covered Benefits in a manner that may be inconsistent with this *EOC*. Under these circumstances, if you have an Emergency Medical Condition or Psychiatric Emergency Medical Condition, call 911 or go to the nearest emergency department as described under "Emergency Services and Care" in the "How to Obtain Covered Benefits" section, and we will provide coverage and reimbursement as described in that section.

Claims Review Authority

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

EOC Binding on Members

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

ERISA Notices

This "ERISA Notices" section applies only if your Group's health benefit plan is subject to the Employee Retirement Income Security Act ("ERISA"). We provide these notices to assist ERISA-covered groups in complying with ERISA. Coverage for services described in these notices is subject to all provisions of this *EOC*.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the birthing person or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the birthing person's or newborn's attending provider, after consulting with the birthing person, from discharging the birthing person or their newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Share applicable to other medical and surgical benefits provided under this plan.

Governing Law

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

Group and Members Not Our Agents

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

Members' Rights and Responsibilities

As a Member, you have a right to:

- Receive information about your rights and responsibilities.
- Receive information about your health plan, the services your health plan offers you, and the Health Care Providers available to care for you.
- Make recommendations regarding the health plan's member rights and responsibilities policy.
- Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the health plan may impose certain limitations on those services.
- Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
- Choose a Health Care Provider in your health plan's network, and change to another doctor in your health plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in your health plan's network, including one with a specialist.
- Have an appointment with a Health Care Provider outside of your health plan's network when your health plan cannot provide timely access to care with an in-network Health Care Provider.
- Certain accommodations for your disability, including:
  - equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
  - full and equal access, as other members of the public, to medical facilities.
  - extra time for visits if you need it.
  - taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
  - Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
  - to be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary treatment of a Mental Health or Substance Use Disorder.

- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services.
- Keep eligible dependent(s) on your health plan. Ask your Group whether Dependents are eligible to enroll under your plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a Health Care Provider.
- Request from your health plan a second opinion by an Appropriately Qualified Health Care Provider.
- Expect your health plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.
- Ask your health plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.
- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your Health Care Provider or medical group leaves your health plan or you are a new health plan member.
- Have an Advance Health Care Directive.
- Be fully informed about your health plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:
  - ♦ your health plan or Health Care Provider.
  - ♦ any care you receive, or access to care you seek.
  - ♦ any covered service or benefit decision that your health plan makes.
  - ♦ any improper charges or bills for care.
  - ♦ any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
  - ♦ not meeting your language needs.
- Know why your health plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your health plan.
- To ask for an Independent Medical Review if your health plan denied, modified, or delayed a health care service.

As a Member, you have the responsibility to:

- Treat all Health Care Providers, Health Care Provider staff, and health plan staff with respect and dignity.
- Share the information needed with your health plan and Health Care Providers, to the extent possible, to help you get appropriate care.
- Participate in developing mutually agreed-upon treatment goals with your Health Care Providers and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to your health plan or Health Care Providers.
- Notify your health plan if you have any changes to your name, address, or family members covered under your health plan.
- Timely pay any Premiums, Cost Share, and charges for non-covered services.
- Notify your health plan as soon as reasonably possible if you are billed inappropriately.

No Waiver

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

Notices Regarding Your Coverage

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call Member Services as soon as possible to give us their new address. If a Member does not reside with the Subscriber, or needs to have confidential information sent to an address other than the Subscriber's address, they should call Member Services to discuss alternate delivery options.

Note: When we tell your Group about changes to this *EOC* or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days (or five days if we terminate your Group's *Agreement*) after receiving the information from us. The Subscriber is also responsible for notifying Group of any change in contact information.

Overpayment Recovery

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

Privacy Practices

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

You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means. You may request confidential communication by completing a confidential communication request form, which is available on **kp.org** under "Request for confidential communications forms." Your request for confidential communication will be valid until you submit a revocation or a new request for confidential communication. If you have questions, call Member Services.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of services. We are sometimes required by law to give protected health information to others, such as government agencies. In addition, protected health information is shared with your Group only with your authorization or as otherwise permitted by law.

We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. OUR *NOTICE OF PRIVACY PRACTICES*, WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY PRACTICES AND YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION, IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. To request a copy, call Member Services. You can also find the notice at a Plan Facility or on our website at **kp.org**.

Public Policy Participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. If you would like to provide input about Health Plan public policy for consideration by the Board, send written comments to:

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

Value-Added Services

In addition to the Covered Benefits that we describe in this *EOC*, we may make available a variety of extra services. Extra services are not covered by your plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

- Certain health education classes not covered by your plan
- Certain health education publications
- Discounts for fitness club memberships
- Wellness programs

Some of these extra services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

- Show your Health Plan ID card
- Pay the fee, if any
- Participate in any required activity

Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as your Plan Deductible or Plan Out-of-Pocket Maximum.

We do not endorse or make any representations regarding the quality or medical efficacy of any extra service, or the financial integrity of the companies offering them. If you encounter any issues regarding extra services, you can contact the company providing the services. You may also call Member Services, and a representative may try to assist in getting the issue resolved. Additionally, you have a right to file a grievance as described under "Grievances" in the "Dispute Resolution" section.

Wellness Programs

You may participate in a wellness program to incentivize healthy activities ("Wellness Program"), which enables you to earn rewards for participating in health and wellness related activities that are designed to benefit you directly either by promoting physical, mental, or emotional wellness, healthy activity, or your general wellbeing.

The Wellness Program is free to participate in and does not require you to make any payment or exchange any item of value in order to participate and earn any available rewards. However, rewards are subject to a maximum cap on the number of rewards you can receive in a calendar year. Once you reach the maximum number of total rewards for the year, completing an activity will not earn a reward, however, to encourage you to continue to engage in healthy behaviors, you will continue to receive the same number of points as the activity would have earned as a reward. Points automatically are entered as entries in promotional contests of chance, also called drawings or promotions, for each additional activity you complete.

The Wellness Program may be available only to Members enrolled through certain groups or plans. Health Plan may engage third-party vendors to administer aspects of the Wellness Program or drawings, consistent with applicable laws and program rules. This third party will ensure all details such as drawing dates, are disclosed in official rules documents that are published on our website. This third party, and not the Health Plan will be responsible for all aspects of these promotions. Additional conditions may apply to promotions, as explained by the administrator, including how to participate without internet access, free alternate methods of entry, eligible activity periods, contact information, and winners lists. Participation in any promotion is always free, and you are never required to make any purchase or provide any consideration, or exchange any item or thing of value, if you choose to voluntarily participate.

To learn about the Wellness Program, related rewards and which ones are available to you, and any applicable terms and conditions such as expiration dates, check our website, **kp.org/rewards**.

Neither the Wellness Programs, nor any promotion accessible in connection with a Wellness Program, is offered as an inducement to purchase a health care plan from us.

Helpful Information

How to Obtain this *EOC* in Other Formats

You can request a copy of this *EOC* in an alternate format (Braille, audio, electronic text file, or large print) by calling Member Services.

Provider Directory

Refer to the Provider Directory for your Service Area for the following information:

- A directory of physicians, licensed health care professionals, and facilities in your Service Area

- A list of Plan Physicians
- The location of Plan Facilities and the types of Covered Benefits that are available from each facility
- Hours of operation
- Appointments and advice phone numbers

This directory is available on our website at **kp.org**. To obtain a printed copy, call Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, call Member Services.

Online Tools and Resources

Here are some tools and resources available on our website at **kp.org**:

- How to use our services and make appointments
- Tools you can use to email your doctor's office, view test results, refill prescriptions, and schedule routine appointments
- Health education resources
- Preventive care guidelines
- Member rights and responsibilities

You can also access tools and resources using the KP app on your smartphone or other mobile device.

Document Delivery Preferences

Many Health Plan documents are available electronically, such as bills, statements, and notices. If you prefer to get documents in electronic format, go to **kp.org** or call Member Services. You can change delivery preference at any time. To get a copy of a specific Heath Plan document in printed format, call Member Services.

How to Reach Us

Appointments

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

Call The appointment phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call Member Services)

Website **kp.org** for routine (non-urgent) appointments with your personal Plan Physician or another Primary Care Physician

Not sure what kind of care you need?

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

Call The appointment or advice phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call Member Services)

Member Services

If you have questions or concerns about your coverage, how to obtain services, or the facilities where you can receive care, you can reach us in the following ways:

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

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

Visit Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

Write Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call Member Services)

Website **kp.org**

Estimates, bills, and statements

For the following concerns, call us at the number below:

- If you have questions about a bill
- To find out how much you have paid toward your Plan Deductible (if applicable) or Plan Out-of-Pocket Maximum
- To get an estimate of Charges for services that are subject to the Plan Deductible (if applicable)

Call **1-800-464-4000** (TTY users call **711**)

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

Website **kp.org**

Away from Home Travel Line

If you have questions about your coverage when you are away from home:

Call **1-951-268-3900**

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

Website **kp.org/travel**

Authorization for Post-Stabilization Care

To request prior authorization for Post-Stabilization Care as described under "Emergency Services and Care" in the "How to Obtain Covered Benefits" section:

Call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card (TTY users call **711**)

24 hours a day, seven days a week

Help with claim forms for Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance services, COVID-19 services, Plan Doula services, and human milk

If you need a claim form to request payment or reimbursement for services described under "Emergency Services and Care and Urgent Care" or "Ambulance Services" in the "Covered Benefits" section, or COVID-19 services under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Pharmacy Services," and "Preventive Services" in the "Covered Benefits" section, or if you need help completing the form, you can reach us by calling or by visiting our website.

Call **1-800-464-4000** (TTY users call **711**)

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

Website **kp.org**

Submitting claims for Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance services, COVID-19 services, Plan Doula services, and human milk

If you need to submit a completed claim form for services described under "Emergency Services and Care and Urgent Care" or "Ambulance Services" in the "Covered Benefits" section, or COVID-19 services under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Pharmacy Services," and "Preventive Services" in the "Covered Benefits" section, or if you need to submit other information that we request about your claim, send it to our Claims Department:

Write Kaiser Permanente
Claims Administration - NCAL
P.O. Box 12923
Oakland, CA 94604-2923

Text telephone access ("TTY")

If you use a text telephone device ("TTY," also known as "TDD") to communicate by phone, you can use the California Relay Service by calling **711**.

Interpreter services

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

Payment Responsibility

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

- Your Group is responsible for paying Premiums, except that you are responsible for paying Premiums if you have COBRA or Cal-COBRA (refer to "Premiums" in the "Premiums, Eligibility, and Enrollment" section and "COBRA" and "Cal-COBRA" under "Continuation of Group Coverage" in the "Continuation of Membership" section)
- Your Group may require you to contribute to Premiums (your Group will tell you the amount and how to pay)
- You are responsible for paying your Cost Share for Covered Benefits (refer to the "Cost Share Summary" section)
- If you receive Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, or COVID-19 services from a Non–Plan Provider, or if you receive emergency ambulance services, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us (refer to "Emergency Services and Care and Urgent Care" in the "Covered Benefits" section)
- If you receive services from Non–Plan Providers that we did not authorize (other than Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance services, or COVID-19 services) and you want us to pay for the care, you must submit a grievance (refer to "Grievances" in the "Dispute Resolution" section)
- If you have coverage with another plan or with Medicare, we will coordinate benefits with the other coverage (refer to "Coordination of Benefits" in the

"Exclusions, Limitations, Coordination of Benefits, and Reductions" section)

- In some situations, you or another party may be responsible for reimbursing us for Covered Benefits (refer to "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- You must pay the full price for non-covered services

Important Notices

Notice of Language Assistance

English: ATTENTION. Timely language assistance is available at no cost to you. You can ask for interpreter services, including sign language interpreters. You can ask for materials translated into your language or alternative formats, such as braille, audio, or large print. You can also request auxiliary aids and devices at our facilities. Call our Member Services department for help. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week

Arabic: انتباه المساعدة اللغوية متوفرة في الوقت المناسب بدون تكلفة عليك. يمكنك طلب خدمات الترجمة، بما في ذلك مترجمي لغة الإشارة. يمكنك طلب وثائق مترجمة بلغتك أو بصيغ بديلة مثل طريقة برايل للمكفوفين أو ملف صوتي أو الطباعة بأحرف كبيرة. يمكنك أيضًا طلب وسائل مساعدة وأجهزة مساعدة في مرافقنا. اتصل مع قسم خدمات الأعضا (Member Services) لدينا للحصول على المساعدة. قسم خدمات الأعضاء مغلق أيام العطلات الرئيسية.

- Medicare، بما في ذلك D-SNP على: **1-800-443-0815** (TTY **711**)، 8 صباحاً إلى 8 مساءً، 7 أيام في الأسبوع
- Medi-Cal: على **1-855-839-7613** (TTY **711**)، 24 ساعة في اليوم، 7 أيام في الأسبوع
- الآخرين جميعاً: **1-800-464-4000** (TTY **711**)، 24 ساعة في اليوم، 7 أيام في الأسبوع

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Ժամանակին տրամադրվող լեզվական աջակցությունը հասանելի է ձեզ անվճար: Դուք կարող եք խնդրել բանավոր թարգմանության ծառայություններ, այդ թվում՝ ժեստերի լեզվի թարգմանիչներ: Դուք կարող եք խնդրել ձեր լեզվով թարգմանված նյութեր կամ այլընտրանքային ձևաչափեր, ինչպիսիք են՝ բրայլը, ձայնագրությունը կամ խոշոր տառատեսակը: Դուք կարող եք նաև դիմել օժանդակ աջակցության և սարքերի համար, որոնք առկա են մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման բաժին: Անդամների սպասարկման բաժինը (Member Services) փակ է հիմնական տոն օրերին:

- Medicare, ներառյալ D-SNP՝ **1-800-443-0815** (TTY **711**), 8 a.m.-ից 8 p.m.-ը, շաբաթը 7 օր
- Medi-Cal՝ **1-855-839-7613** (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր
- Մյուս բոլորը՝ **1-800-464-4000** (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր

Chinese：请注意。我们免费为您提供及时语言协助。您可以要求我们提供口译服务，包括手语翻译员。您可以要求将资料翻译成您所使用的语言或其他格式，如盲文版、音频版或大字版。您还可以要求在我们的设施使用语言辅助工具和设备。请致电会员服务部(Member Services)以获取帮助。会员服务部于重要节假日休息。

- 联邦医疗保险计划 (Medicare)，包括 D-SNP：**1-800-443-0815** (TTY **711**)，每周 7 天，上午 8:00 至晚上 8:00
- 加州医疗保健辅助计划：**1-855-839-7613** (TTY **711**)，每周 7 天，每天 24 小时
- 所有其他计划：**1-800-757-7585** (TTY **711**)，每周 7 天，每天 24 小时

Farsi: توجه. امکان بهره‌مندی به‌موقع و مقتضی از مساعدت زبانی به طور رایگان برای شما وجود دارد. می‌توانید خدمات ترجمه شفاهی را درخواست کنید، از جمله مترجمان زبان اشاره. همچنین می‌توانید مطالب ترجمه‌شده به زبان خودتان یا در قالب‌های جایگزین را درخواست کنید، از جمله خط بریل، فایل صوتی، یا چاپ با حروف درشت. همچنین می‌توانید امکانات و دستگاه‌های کمکی را از مراکز ما درخواست کنید. برای دریافت کمک، با بخش خدمات اعضای ما (Member Services) تماس بگیرید. بخش خدمات اعضا در تعطیلات رسمی تعطیل می‌باشد.

- Medicare، شامل D-SNP: با شماره **1-800-443-0815** (TTY **711**) از 8 صبح تا 8 عصر، در 7 روز هفته تماس بگیرید
- Medi-Cal: با شماره **1-855-839-7613** (TTY **711**)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید
- همه موارد دیگر: با شماره **1-800-464-4000** (TTY **711**)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید

Hindi: ध्यान दें। समय पर भाषा सहायता आपके लिए बिना किसी शुल्क के उपलब्ध है। आप दुभाषिया सेवाओं के लिए अनुरोध कर सकते हैं, जिसमें साइन लैंगुवेज के दुभाषिये भी शामिल हैं। आप सामग्रियों को अपनी भाषा या वैकल्पिक प्रारूप, जैसे कि ब्रेल, ऑडियो, या बड़े प्रिंट में अनुवाद करवाने के लिए भी कह सकते हैं। आप हमारे सुविधा-केंद्रों पर सहायक साधनों और उपकरणों का भी अनुरोध कर सकते हैं। सहायता के लिए हमारे सदस्य सेवा (Member Services) विभाग को कॉल करें। सदस्य सेवा विभाग मुख्य छुट्टियों वाले दिन बंद रहता है।

- Medicare, जिसमें D-SNP शामिल है: **1-800-443-0815** (TTY **711**), सुबह 8 बजे से रात 8 बजे तक, सप्ताह के 7 दिन
- Medi-Cal: **1-855-839-7613** (TTY **711**), दिन के चौबीस घंटे, सप्ताह के 7 दिन
- बाकी सभी: **1-800-464-4000** (TTY **711**), दिन के चौबीस घंटे, सप्ताह के 7 दिन

Hmong: CEEB TOOM. Sij hawm muaj kev pab txhais lus pub dawb rau koj. Koj muaj peev xwm thov kom pab txhais lus, suav nrog kws txhais lus piav tes. Koj muaj peev xwm thov kom muab cov ntaub ntawv no txhais ua koj yam lus los sis ua lwm hom, xws li hom ntawv rau neeg dig muag xuas, tso ua suab lus, los sis luam tawm kom koj. Koj kuj tuaj yeem thov kom muab tej khoom pab dawb thiab tej khoom siv txhawb tau rau

ntawm peb cov chaw kuaj mob. Hu mus thov kev pab rau ntawm peb Lub Chaw Pab Cuam Tswv Cuab. Lub Chaw Pab Cuam (Member Services) Tswv Cuab raug kaw rau cov hnub so tseem ceeb.

- Medicare, suav nrog D-SNP: **1-800-443-0815** (TTY **711**), 8 teev sawv ntxov txog 8 teev tsaus ntuj, 7 hnub hauv ib lub vij
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 teev hauv ib hnub, 7 hnub hauv ib lub vij
- Tag nrho lwm yam: **1-800-464-4000** (TTY **711**), 24 teev hauv ib hnub, 7 hnub hauv ib lub vij

Japanese：注意。タイムリーな言語サポートを無料でご利用いただけます。あなたは手話通訳を含む通訳サービスを依頼できます。点字、大型活字、または録音音声など、あなたの言語に翻訳された資料や別のフォーマットの資料を求めることができます。当社の施設では補助器具や機器の要請も承っております。支援が必要な方は、加入者サービス部門 (Member Services) にお電話ください。加入者向けサービスは、主要な休日には営業しておりません。

- D-SNP を含む Medicare: **1-800-443-0815** (TTY **711**)、午前 8 時から午後 8 時まで、年中無休
- Medi-Cal: **1-855-839-7613** (TTY **711**)、24 時間、年中無休
- その他全て: **1-800-464-4000** (TTY **711**)、24 時間、年中無休

Khmer (Cambodian): យកចិត្តទុកដាក់។
ជំនួយភាសាទាន់ពេលវេលាអាចរកបានដោយមិនគិតថ្លៃសម្រាប់អ្នក។
អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ រួមទាំងអ្នកបកប្រែភាសាសញ្ញាផងដែរ។
អ្នកអាចស្នើសុំឯកសារដែលត្រូវបានបកប្រែជាភាសារបស់អ្នក
ឬទម្រង់ផ្សេងទៀតដូចជាអក្សរស្ដាប សំឡេង ឬអក្សរធំៗ។ អ្នកក៏អាចស្នើសុំជំនួយបន្ថែម និងឧបករណ៍ជំនួយនៅតាមកន្លែងរបស់យើងផងដែរ។
សូមទូរសព្ទទៅផ្នែកសេវាសមាជិករបស់យើងសម្រាប់ជំនួយ។
សេវាកម្មសមាជិកត្រូវបានបិទនៅថ្ងៃឈប់សម្រាកសំខាន់ៗ (Member Services)។

- Medicare រួមទាំង D-SNP: **1-800-443-0815** (TTY **711**) ពីម៉ោង 8 ព្រឹក ដល់ 8 យប់ 7 ថ្ងៃក្នុងមួយសប្ដាហ៍
- Medi-Cal: **1-855-839-7613** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្ដាហ៍
- ផ្សេងៗទៀតទាំងអស់៖ **1-800-464-4000** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្ដាហ៍

Korean: 참고. 무료로 시기적절한 언어 지원을 제공합니다. 수화 통역사를 포함한 통역 서비스를 요청할 수 있습니다. 한국어로 번역된 자료 또는 점자, 오디오 또는 큰 글씨와 같은 대체 형식의 자료를 요청할 수 있습니다. 저희 시설에서 보조 기구와 장치를 요청할 수도 있습니다. 가입자 서비스 (Member Services) 부서에 전화하여 도움을 요청하십시오. 주요 공휴일에는 가입자 서비스를 운영하지 않습니다.

- Medicare(D-SNP 포함): 주 7 일 오전 8 시~오후 8 시에 **1-800-443-0815** (TTY **711**)번으로 문의
- Medi-Cal: **1-855-839-7613** (TTY **711**), 주 7 일, 하루 24 시간
- 기타 모두: **1-800-464-4000** (TTY **711**), 주 7 일, 하루 24 시간

Laotian: ຂໍ້ຄວນເອົາໃຈໃສ່. ມີການຊ່ວຍເຫຼືອດ້ານພາສາຢ່າງທັນເວລາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍບໍລິການລ່າມແປພາສາ, ລວມທັງລ່າມແປພາສາມື.
ທ່ານສາມາດຂໍເອກະສານທີ່ແປເປັນພາສາຂອງທ່ານ ຫຼື ຮູບແບບອື່ນ ເຊັ່ນ: ອັກສອນນູນ, ສຽງ ຫຼື ຕົວພິມໃຫຍ່. ນອກຈາກນີ້ ທ່ານຍັງສາມາດຮ້ອງຂໍເຄື່ອງຊ່ວຍເຫຼືອ ແລະ ອຸປະກອນເສີມໄດ້ທີ່ສະຖານທີ່ຍ່ານພະຍາບານຂອງພວກເຮົາ. ໂທຫາພະແນກການບໍລິການສະມາຊິກ (Member Services) ຂອງພວກເຮົາສຳລັບການຊ່ວຍເຫຼືອ. ການບໍລິການສະມາຊິກຈະປິດໃນວັນພັກສຳຄັນ.

- Medicare, ລວມທັງ D-SNP: **1-800-443-0815** (TTY **711**), 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ, 7 ມື້ຕໍ່ອາທິດ
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ
- ທັງໝົດອື່ນໆ: **1-800-464-4000** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ

Mien: MBUOX JANGX-FIM WAAC. Ninh mbuo duqv liepc ziangx tengx faan waac bun meih muangx hingh mv zuqc hoic meih ndortv nyaanh cingv oc. Meih corc haiv tov taux ninh mbuo tengx lorz faan waac bun meih, caux longc buoz wuv faan waac bun muangx. Meih aengx haih tov taux ninh mbuo dorh nyungc horngh jaa dorngx faan benx meih nyei waac a'fai fiev bieqc da'nyeic diuc daan, fiev benx domh nzangc-pokc bun hluo, bungx waac-qiez bun uangx, a'fai aamx bieqc domh zeiv-linh. Meih corc haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Mborqv finx lorz taux yie mbuo dinc zangc domh gorn ziux goux baengc mienh nyei dorngx liouh tov heuc ninh mbuo tengx nzie weih. Goux baengc mienh nyei dorngx duqv guon mv zoux gong yiem gingc nyei hnoi-nyieqc oc (Member Services).

- Medicare, caux D-SNP: **1-800-443-0815** (TTY **711**), yiem 8 dimv lungh ndorm taux 8 dimv lungh muonx, yietc norm leiz baaix zoux gong 7 hnoi
- Medi-Cal: **1-855-839-7613** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi
- Yietc zungv da'nyeic diuc jauv-louc: **1-800-464-4000** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi

Navajo: YÁ'ÁDÍÍŁTĮĮH. T'áá Bíní'dée'go Bizaad Bee Na'anish Bééhózin, Doo BéeNOLso Bee Na'al'a' Da. Tł'éé'góó tł'ízí'ígíí éí tséé' naalkáah sidá'ígíí bikáa' dah sidaaígíí, t'á'ii bik'eh dah na'ałkaígíí. T'á'ii éí tł'éé'góó tł'ízí'ígíí bik'eh dah deidiyós, t'á'ii éí bi'éé' bik'eh dah na'ałkaígíí bik'eh dah deidiyós. T'á'ii bik'eh dah na'ałkaígíí bikáa' dah na'ałkaígíí t'áá ałtso bik'eh dah deidiyós. Bi'éé' naalkáah sidá'ígíí bik'eh ha'a'aah. T'á'ii bik'eh dah na'ałkaígíí éí bik'eh dah naazhjaa'ígíí bik'eh dah na'ałkaígíí (Member Services).

- Medicare, 'ałdó' bii' hóló D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. góó 8 p.m., 7 jį t'ááłá'í damóo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 tł'ohch'oolí t'ááłá'í jį, 7 jį t'ááłá'í damóo
- T'áá ał'ąą: **1-800-464-4000** (TTY **711**), 24 tł'ohch'oolí t'ááłá'í jį, 7 jį t'ááłá'í damóo

Punjabi: ਧਿਆਨ ਦਿਓ। ਸਮੇਂ ਸਿਰ ਦਿੱਤੀ ਜਾਣ ਵਾਲੀ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ਿਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਿੱਤੇ ਜਾਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ, ਜਿਸ ਵਿੱਚ ਸਾਈਨ ਲੈਂਗੁਵੇਜ਼ ਦੇ ਦੁਭਾਸ਼ਿਏ ਵੀ ਸ਼ਾਮਲ ਹਨ। ਤੁਸੀਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ, ਜਾਂ ਕਿਸੇ ਵੈਕਲਪਿਕ ਫਾਰਮੈਟ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ, ਆਡੀਓ, ਜਾਂ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਅਨੁਵਾਦਿਤ ਕਰਨ ਲਈ ਵੀ ਕਹਿ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸਹੂਲਤਾਂ 'ਤੇ ਸਹਾਇਕ

ਏਡਜ਼ ਅਤੇ ਉਪਕਰਨਾਂ ਲਈ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ ਸਾਡੇ ਮੈਂਬਰਾਂ ਸੇਵਾਵਾਂ (Member Services) ਦੇ ਵਿਭਾਗ ਨੂੰ ਕਾੱਲ ਕਰੋ। ਮੈਂਬਰਾਂ ਸੇਵਾਵਾਂ ਦਾ ਵਿਭਾਗ ਮੁੱਖ ਛੁਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ।

- Medicare, ਬਜਸ ਬਵੱ D-SNP ਵੀ ਸ਼ਾਮਲ ਹੈ: **1-800-443-0815** (TTY **711**), ਸਵੇਰੇ 8 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8 ਵਜੇ ਤੱਕ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- Medi-Cal: **1-855-839-7613** (TTY **711**), ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- ਬਾਕੀ ਸਾਰੇ: **1-800-464-4000** (TTY **711**), ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ

Russian: ВНИМАНИЕ! Для Вас доступны бесплатные услуги перевода. Вы можете запросить услуги устного перевода, в том числе услуги переводчика языка жестов. Вы также можете запросить материалы, переведенные на ваш язык или в альтернативных форматах, например шрифтом Брайля, крупным шрифтом или в аудиоформате. Вы также можете запросить дополнительные приспособления и вспомогательные устройства в наших учреждениях. Если Вам нужна помощь, позвоните в отдел обслуживания участников. Отдел обслуживания участников (Member Services) не работает в дни государственных праздников.

- Medicare, включая D-SNP: **1-800-443-0815** (линия TTY **711**), ежедневно с 8:00 до 20:00.
- Medi-Cal: **1-855-839-7613** (линия TTY **711**), круглосуточно, ежедневно.
- Любые другие поставщики услуг: **1-800-464-4000** (линия TTY **711**), круглосуточно, ежедневно.

Spanish: ATENCIÓN. Se ofrece ayuda oportuna en otros idiomas sin ningún costo para usted. Puede solicitar servicios de interpretación, incluyendo intérpretes de lengua de señas. Puede solicitar materiales traducidos a su idioma o en formatos alternativos, como braille, audio o letra grande. También puede solicitar ayuda adicional y dispositivos auxiliares en nuestros centros de atención. Llame al Departamento de Servicio a los Miembros (Member Services) para pedir ayuda. Servicio a los Miembros está cerrado los días festivos principales.

- Medicare, incluyendo D-SNP: **1-800-443-0815** (TTY **711**), los 7 días de la semana, de 8 a. m. a 8 p. m., los 7 días de la semana
- Medi-Cal: **1-855-839-7613** (TTY **711**), las 24 horas del día, los 7 días de la semana.
- Todos los demás: **1-800-788-0616** (TTY **711**), las 24 horas del día, los 7 días de la semana.

Tagalog: ATENSYON. Ang napapanahong tulong sa wika ay makukuha nang walang bayad para sa iyo. Maaari kang humiling ng mga serbisyo ng interpreter, kasama ang mga interpreter sa sign language. Maaari kang humiling ng mga babasahin na nakasalin-wika sa iyong wika o sa mga alternatibong format, na tulad ng braille, audio, o malalaking titik. Puwede ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan ang aming departamento ng Mga Serbisyo sa Miyembro (Member Services) para sa tulong. Ang Mga Serbisyo sa Miyembro ay sarado sa mga pangunahing holiday.

- Medicare, kasama ang D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. hanggang 8 p.m., 7 araw sa isang linggo

- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo
- Ang lahat ng iba: **1-800-464-4000** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo

Thai: ส่งถึง มีบริการความช่วยเหลือด้านภาษาอย่างทันท่วงทีให้ท่านโดยไม่มีค่าใช้จ่าย ท่านสามารถขอรับบริการล่าม รวมถึงล่ามภาษามือได้ ท่านสามารถขอให้แปลเอกสารเป็นภาษาของท่าน หรือในรูปแบบอื่นๆ เช่นอักษรเบรลล์ ไฟล์เสียง หรือตัวอักษรขนาดใหญ่ ท่านสามารถขอรับอุปกรณ์ช่วยเหลือและอุปกรณ์เสริมได้ ณ สถานที่ให้บริการของเรา โทรติดต่อฝ่ายบริการสมาชิกของเรา (Member Services) เพื่อขอความช่วยเหลือได้ ฝ่ายบริการสมาชิกจะปิดทำการในวันหยุดราชการต่างๆ

- Medicare รวมถึง D-SNP: **1-800-443-0815** (TTY **711**) 8.00 น. ถึง 20.00 น.หรือ 7 วันต่อสัปดาห์
- Medi-Cal: **1-855-839-7613** (TTY **711**) ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์
- อื่นๆ ทั้งหมด: **1-800-464-4000** (TTY **711**) ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์

Ukrainian: УВАГА! Своєчасні послуги перекладача надаються безкоштовно. Ви можете залишити запит на послуги усного перекладу, зокрема мовою жестів. Ви можете зробити запит на отримання матеріалів, перекладених вашою мовою, або в альтернативних форматах, як-от надрукованим шрифтом Брайля чи великим шрифтом, а також у звуковому форматі. Крім того, ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Якщо вам потрібна допомога, зателефонуйте у відділ обслуговування клієнтів (Member Services). Відділ обслуговування клієнтів зачинений у державні свята.

- Medicare, зокрема D-SNP: **1-800-443-0815** (TTY **711**), із 8:00 до 20:00, без вихідних.
- Medi-Cal: **1-855-839-7613** (TTY **711**), цілодобово, без вихідних.
- Усі інші надавачі послуг: **1-800-464-4000** (TTY **711**), цілодобово, без вихідних.

Vietnamese: LƯU Ý. Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ kịp thời, miễn phí cho quý vị. Quý vị có thể yêu cầu dịch vụ thông dịch, bao gồm cả thông dịch viên ngôn ngữ ký hiệu. Quý vị có thể yêu cầu tài liệu được dịch sang ngôn ngữ của quý vị hay định dạng thay thế, chẳng hạn như chữ nổi braille, băng đĩa thu âm hay bản in khổ chữ lớn. Quý vị cũng có thể yêu cầu các phương tiện và thiết bị phụ trợ tại các cơ sở của chúng tôi. Gọi cho ban Dịch Vụ Hội Viên (Member Services) của chúng tôi để được trợ giúp. Ban Dịch Vụ Hội Viên không làm việc vào những ngày lễ lớn.

- Medicare, bao gồm cả D-SNP: **1-800-443-0815** (TTY **711**), 8 giờ sáng đến 8 giờ tối, 7 ngày trong tuần
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần
- Mọi chương trình khác: **1-800-464-4000** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần.

Nondiscrimination Notice

In this document, "we", "us", or "our" means Kaiser Permanente (Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., and the Southern California Medical Group). This notice is available on our website at **kp.org**.

Discrimination is against the law. We follow state and federal civil rights laws.

We do not discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services in a timely manner:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Services department at the numbers below. The call is free. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week.
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week.
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week.

Upon request, this document can be made available to you in braille, large print, audio, or electronic formats. To obtain a copy in one of these alternative formats, or another format, call our Member Services department and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Call our Member Services department. Phone numbers are listed above.
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at **kp.org/facilities** for addresses)

- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office for Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office for Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Office of Civil Rights
  Department of Health Care Services
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  California Department of Health Care Services Office for Civil Rights Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx

- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office for Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  U.S. Department of Health and Human Services Office for Civil Rights Complaint forms are available at: https://www.hhs.gov/ocr/office/file/index.html

- **Online:** Visit the **Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

EOC #4 - Chiropractic Services Amendment of the Kaiser Foundation Health Plan, Inc. Evidence of Coverage for
ACTIVISION PUBLISHING, INC. DBA: ACTIVISION BLIZZARD

Group ID: 602873 Contract: 1 Version: 35 *EOC* Number: 4 Issue Date: October 1, 2026

January 1, 2027, through December 31, 2027

ASH Plans Customer Service Department
Monday through Friday
1-800-678-9133 (TTY users call **711**) toll free
ashlink.com/ash/kp

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Benefit Highlights

We cover the services described below, subject to exclusions described in the "Exclusions" section, only if all of the following conditions are satisfied:

- You are a Member on the date that you receive the services
- ASH Plans has determined that the services are Medically Necessary, except as described in this Amendment
- You receive the services from ASH Participating Providers or other licensed providers that ASH contracts to provide covered care, except as described in this Amendment

Professional services (ASH Participating Provider office visits)	**You Pay**
Chiropractic office visits (up to a total of 30 visits per 12-month period) ..	$10 per visit
Other	**You Pay**
X-rays and laboratory tests that are covered Chiropractic services.....	No charge
Chiropractic supports and appliances	Amounts in excess of the $50 Allowance

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, refer to the "Covered Benefits" and "Exclusions" sections.

Introduction

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

- "How to Obtain Services" (except that the "Completion of Services from Non–Plan Providers" section, or for Kaiser Permanente Senior Advantage Members, the "Termination of a Plan Provider's contract and completion of Services" section, does apply to coverage described in this document)
- "Plan Facilities"
- "Emergency Services and Urgent Care"
- "Benefits"

Kaiser Foundation Health Plan, Inc. contracts with American Specialty Health Plans of California, Inc. ("ASH Plans") to make the network of ASH Participating Providers available to you.

When you need chiropractic care, you have direct access to thousands of licensed chiropractors in California. You can obtain Covered Benefits from any ASH Participating Provider without a referral from a Plan Physician. Your Cost Share is due when you receive Covered Benefits.

Definitions

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

ASH Participating Provider: A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide Medically Necessary Chiropractic services to you. A list of ASH Participating Providers is available on the ASH Plans website at **ashlink.com/ash/kaisercamedicare** for Kaiser Permanente Senior Advantage Members, or **ashlink.com/ash/kp** for all other Members, or from the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**). The list of ASH Participating Providers is subject to change at any time, without notice. If you have questions, please call the ASH Plans Customer Service Department.

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

Chiropractic services: Chiropractic services include spinal and extremity manipulation and adjunctive therapies such as ultrasound, therapeutic exercise, or electrical muscle stimulation, when provided during the same course of treatment and in conjunction with chiropractic manipulative services, and other services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic supports and appliances) for the treatment of your Musculoskeletal and Related Disorder.

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

Musculoskeletal and Related Disorders: Conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and Related Disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs and synovial structures) and related manifestations or conditions.

Non–Participating Provider: A provider other than an ASH Participating Provider.

Treatment Plan: The course of treatment for your Musculoskeletal and Related Disorder, which may include laboratory tests, X-rays, chiropractic supports and appliances, and a specific number of visits for chiropractic manipulations (adjustments) and adjunctive therapies that are Medically Necessary Chiropractic services for you.

Urgent Chiropractic services: Chiropractic services that meet all of the following requirements:

- They are necessary to prevent serious deterioration of your health resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy
- They cannot be delayed until you return to the Service Area

ASH Participating Providers

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

ASH Plans contracts with ASH Participating Providers and other licensed providers to provide the services covered under this Amendment (including laboratory tests, X-rays, and chiropractic supports and appliances). You must receive services covered under this Amendment from an ASH Participating Provider or another licensed provider with which ASH contracts to provide covered care, except for services covered under "Emergency and Urgent Services Covered Under this Amendment" in the "Covered Benefits" section and services that are not available from contracted providers and that are authorized in advance by ASH Plans.

How to Obtain Services

To obtain services covered under this Amendment call an ASH Participating Provider to schedule an initial examination. If additional services are required after the initial examination, verification that the services are Medically Necessary may be required, as described under "Decision time frames" below. Your ASH Participating Provider will request any required medical necessity determinations. An ASH Plans clinician in the same or similar specialty as the provider of services under review will determine whether the services are or were Medically Necessary services.

Decision time frames

The ASH Plans' clinician will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after receiving all of the information (including additional examination and test results) reasonably necessary to make the decision, except that decisions about urgent services will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If ASH Plans 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 ASH Participating Provider will be informed in writing about the additional information, testing, or specialist that is needed, and the date that ASH Plans expects to make a decision.

Your ASH Participating Provider will be informed of the decision within 24 hours after the decision is made. If the services are authorized, your ASH Participating Provider will be informed of the scope of the authorized services. If ASH Plans does not authorize all of the services, ASH Plans will send you a written decision and explanation, including the rationale for the decision and the criteria used to make the decision, within two business days after the decision is made. The letter will also include information about your appeal rights, which are described in the "Coverage Decisions, Appeals, and Complaints" section of your Health Plan *EOC* for Kaiser Permanente Senior Advantage Members, and "Dispute Resolution" section of your Health Plan *EOC* for all other Members. Any written criteria that ASH Plans uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request. If you have questions or concerns, please contact ASH Plans or Kaiser Permanente as described under "Customer Service" in this Amendment.

Covered Benefits

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

- You are a Member on the date that you receive the services
- ASH Plans has determined that the services are Medically Necessary, except for:
  - the initial examination described under "Office Visits" in this "Covered Benefits" section
  - services covered under "Emergency and Urgent Services Covered Under this Amendment" in this "Covered Benefits" section
- You receive the services from ASH Participating Providers or other licensed providers with which ASH contracts to provide covered care, except for:
  - services covered under "Emergency and Urgent Services Covered Under this Amendment" in this "Covered Benefits" section
  - services that are not available from ASH Participating Providers or other licensed providers with which ASH contracts to provide covered care and that are authorized in advance by ASH Plans

When you receive Covered Benefits, you must pay the Cost Share listed in this "Covered Benefits" section. If you receive services that are not covered under this Amendment, you may be liable for the full price of those services.

Note: If Charges for services are less than the Copayment described in this "Covered Benefits" section, you will pay the lesser amount.

The Cost Share you pay for services covered under this Amendment does not apply toward any Plan Deductible or Plan Out-of-Pocket Maximum described in your Health Plan *EOC*.

If you have questions about your Cost Share for specific services that you are scheduled to receive or that your provider orders during a visit or procedure, please call the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**) weekdays.

If you are a Kaiser Permanente Senior Advantage Member, refer to your Health Plan *EOC* for information about the chiropractic services that we cover in accord with Medicare guidelines, which are separate from the services covered under this Amendment.

Office Visits

We cover the following:

- **Initial chiropractic examination:** An examination performed by an ASH Participating Provider to determine the nature of your problem (and, if appropriate, to prepare a Treatment Plan), and to provide Medically Necessary Chiropractic services, which may include an adjustment and adjunctive therapy. We cover an initial examination only if you have not already received covered Chiropractic services from an ASH Participating Provider in the same 12-month period for your Musculoskeletal and Related Disorder
- **Subsequent chiropractic office visits:** Subsequent ASH Participating Provider office visits for Chiropractic services that are determined to be Medically Necessary by an ASH Plans clinician. These subsequent office visits may include an adjustment, adjunctive therapy, and a re-examination to assess the need to continue, extend, or change a Treatment Plan

Each office visit counts toward any visit limit, if applicable.

You pay the following for these Covered Benefits (up to 30 visits per 12 month period): **a $10 Copayment per visit**

Laboratory Tests and X-rays

We cover Medically Necessary laboratory tests and X-rays when prescribed as part of covered chiropractic care described under "Office Visits" in this "Covered Benefits" section at **no charge** when an ASH Participating Provider provides the services or refers you to another licensed provider with which ASH contracts to provide Covered Benefits.

Chiropractic Supports and Appliances

We provide a **$50 Allowance per 12-month period** toward the ASH Plans fee schedule price for chiropractic appliances listed in this paragraph when the item is prescribed and provided to you by an ASH Participating Provider as part of covered chiropractic care described under "Office Visits" in this "Covered Benefits" section. If the price of the items in the ASH Plans fee schedule exceeds $50 (the Allowance), you will pay the amount in excess of $50 (and that payment does not apply toward the Plan Out-of-Pocket Maximum described in your Health Plan *EOC*). Covered chiropractic appliances are limited to: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports, and wrist braces.

Second Opinions

You may request a second opinion in regard to Covered Benefits by contacting another ASH Participating Provider. Your visit to another ASH Participating Provider for a second opinion generally will count toward any visit limit, if applicable. An ASH Participating Provider may also request a second opinion in regard to Covered Benefits by referring you to another ASH Participating Provider in the same or similar specialty. If you are referred by an ASH Participating Provider to another ASH Participating Provider, or you see an ASH Participating Provider for lab work or an X-ray, your visit to the other ASH Participating Provider will not count toward any visit limit. An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is denied, you will be notified in writing of the reasons for the denial, and of your right to file a grievance as described under "Grievances" in this Amendment.

Emergency and Urgent Services Covered Under this Amendment

We cover Emergency Chiropractic services and Urgent Chiropractic services provided by an ASH Participating Provider or a Non–Participating Provider at **a $10 Copayment per visit**. We do not cover follow-up or continuing care from a Non-Participating Provider unless ASH Plans has authorized the services in advance. Also, we do not cover services from a Non-Participating Provider that ASH Plans determines are not Emergency Chiropractic services or Urgent Chiropractic services.

How to file a claim

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

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

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage under this Amendment. (Note: Some items and services listed in this "Exclusions" section may be Covered Benefits under your Health Plan *EOC*. Please refer to your Health Plan *EOC* for details.) These exclusions apply to all services that would otherwise be covered under this Amendment regardless of whether the services are within the scope of a provider's license or certificate:

- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California
- Adjunctive therapy not associated with spinal, muscle, or joint manipulations
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered under "Chiropractic Supports and Appliances" in the "Covered Benefits" section of this Amendment
- Services for asthma or addiction, such as nicotine addiction
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational services. If coverage for a service is denied because it is experimental or investigational and you want to appeal the denial, refer to your Health Plan *EOC* for information about the appeal process
- CT scans, MRIs, PET scans, bone scans, nuclear medicine, and any other type of diagnostic imaging or radiology other than X-rays covered under the "Covered Benefits" section of this Amendment
- Ambulance and other transportation
- Education programs, non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation
- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California, except for services covered under "Emergency and Urgent Services Covered Under this Amendment" in the "Covered Benefits" section
- Hospital services, anesthesia, manipulation under anesthesia, and related services
- Dietary and nutritional supplements, such as vitamins, minerals, herbs, herbal products, injectable supplements, and similar products
- Massage therapy
- Maintenance care (services provided to Members whose treatment records indicate that they have reached maximum therapeutic benefit)

Customer Service

If you have a question or concern regarding the services you received from an ASH Participating Provider or any other licensed provider with which ASH contracts to provide Covered Benefits, you may call the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**) weekdays, or write ASH Plans at:

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

Grievances

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