Kaiser Foundation Health Plan, Inc.
Northern and Southern California Regions

2007 DISCLOSURE FORM FOR KAISER PERMANENTE FOR INDIVIDUALS AND FAMILIES COPAYMENT PLANS AND DEDUCTIBLE PLANS

Your Health Plan Coverage

January 1, 2007, through December 31, 2007

Member Service Call Center
1-800-464-4000
Weekdays 7 a.m.–7 p.m.
Weekends 7 a.m.–3 p.m.
(except holidays)

31484

TABLE OF CONTENTS

Health Plan Benefits and Coverage Matrix for the $1,500 Deductible Plan . . . 1
Health Plan Benefits and Coverage Matrix for the $500 Deductible Plan. 4
Health Plan Benefits and Coverage Matrix for the $50 Copayment Plan 7
Health Plan Benefits and Coverage Matrix for the $25 Copayment Plan 10
Introduction. 13
How to obtain care 14
Plan Facilities and *Your Guidebook* 16
Your primary care Plan Physician 17
Getting a referral 17
Second opinions 19
How Plan Providers are paid 19
Your costs 20
Reimbursement for Emergency, Post-stabilization, or
Out-of-Area Urgent Care 21
Termination of benefits 22
Rescission of membership 24
Individual continuation of benefits for Dependents 24
Getting assistance 24
Dispute resolution and binding arbitration 25
Renewal provisions 26
Principal exclusions, limitations, and reductions of benefits 26
To become a Member 28
Miscellaneous notices 30
Definitions 33

Health Plan Benefits and Coverage Matrix for the $1,500 Deductible Plan

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

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

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

Annual Out-of-Pocket Maximum for Certain Services	
For any one Member in the same Family Unit	$3,500 per calendar year
For an entire Family Unit of two or more Members	$7,000 per calendar year
Copayments and Coinsurance for most Services and all Deductible payments (except prescription drugs) count toward this maximum as described in the *Evidence of Coverage*.	
Deductible for Certain Services	
For any one Member in the same Family Unit	$1,500 per calendar year
For an entire Family Unit of two or more Members	$3,000 per calendar year
Deductible for Certain Drugs	$250 per calendar year
Lifetime Maximum	None
Coordination of Benefits	Included
Professional Services (Plan Provider office visits)	**You Pay**
Primary and specialty care visits (includes routine and Urgent Care appointments)	$30 per visit after Deductible
Routine preventive physical exams	$30 per visit (Deductible doesn't apply)
Well-child preventive care visits (0–23 months)	$30 per visit (Deductible doesn't apply)
Family planning visits	$30 per visit (Deductible doesn't apply)

Scheduled prenatal care and first postpartum visit	$30 per visit (Deductible doesn't apply)
Voluntary termination of pregnancy	$30 per procedure after Deductible
Eye exams	$30 per visit (Deductible doesn't apply)
Hearing tests	$30 per visit (Deductible doesn't apply)
Chiropractic office visits (up to 20 visits per calendar year)	$15 per visit (Deductible doesn't apply)
Physical, occupational, and speech therapy visits	$30 per visit after Deductible
Outpatient Services	**You Pay**
Outpatient surgery	$250 per procedure after Deductible
Allergy injection visits	$5 per visit after Deductible
Allergy testing visits	$30 per visit after Deductible
Vaccines (immunizations)	No charge (Deductible doesn't apply)
Most X-rays and lab tests	$10 per encounter (except that MRI, CT, and PET are $50 per procedure) after Deductible
Preventive screenings described in the *Evidence of Coverage*	$10 per encounter (Deductible doesn't apply)
Health education	$30 per individual visit (Deductible doesn't apply) No charge for group visits (Deductible doesn't apply)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	$500 per day after Deductible
Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit after Deductible
Ambulance Services	**You Pay**
Ambulance Services	$150 per trip after Deductible
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary from Plan Pharmacies:	
Generic items	$10 for up to a 100 day supply

Brand name items	$35 for up to a 100 day supply after $250 drug Deductible
Durable Medical Equipment	**You Pay**
Most DME items are **not covered**, please refer to the *Evidence of Coverage* to learn which items are covered	30% Coinsurance (Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric care (up to 10 days per calendar year)	$500 per day after Deductible
Outpatient visits:	
Up to a total of 10 individual and group therapy visits per calendar year	$30 per individual therapy visit after Deductible $15 per group therapy visit after Deductible
Up to 30 additional group therapy visits that meet the Medical Group criteria in the same calendar year	$15 per group therapy visit after Deductible
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	$500 per day after Deductible
Outpatient individual therapy visits	$30 per visit after Deductible
Outpatient group therapy visits	$5 per visit after Deductible
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission after Deductible
Home Health Services	**You Pay**
Home health care (up to 100 two-hour visits per calendar year)	No charge (Deductible doesn't apply)
Other	**You Pay**
Skilled nursing facility care (up to 60 days per benefit period)	$50 per day after Deductible
Hospice care	No charge (Deductible doesn't apply)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Deductibles, exclusions, or limitations, and it does not list all benefits, Copayments, and Coinsurance. For a complete explanation, please refer to the *Evidence of Coverage*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Health Plan Benefits and Coverage Matrix for the $500 Deductible Plan

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

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

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

Annual Out-of-Pocket Maximum for Certain Services	
For any one Member in the same Family Unit	$2,500 per calendar year
For an entire Family Unit of two or more Members	$5,000 per calendar year
Copayments and Coinsurance for most Services and all Deductible payments (except prescription drugs) count toward this maximum as described in the *Evidence of Coverage.*	
Deductible for Certain Services	
For any one Member in the same Family Unit	$500 per calendar year
For an entire Family Unit of two or more Members	$1,000 per calendar year
Deductible for Certain Drugs	$250 per calendar year
Lifetime Maximum	None
Coordination of Benefits	Included
Professional Services (Plan Provider office visits)	**You Pay**
Primary and specialty care visits (includes routine and Urgent Care appointments)	$20 per visit after Deductible
Routine preventive physical exams	$20 per visit (Deductible doesn't apply)
Well-child preventive care visits (0–23 months)	No charge (Deductible doesn't apply)
Family planning visits	$20 per visit (Deductible doesn't apply)

Scheduled prenatal care and first postpartum visit	No charge (Deductible doesn't apply)
Voluntary termination of pregnancy	$20 per procedure after Deductible
Eye exams	$20 per visit (Deductible doesn't apply)
Hearing tests	$20 per visit (Deductible doesn't apply)
Physical, occupational, and speech therapy visits	$20 per visit after Deductible
Outpatient Services	**You Pay**
Outpatient surgery	$50 per procedure after Deductible
Allergy injection visits	$5 per visit after Deductible
Allergy testing visits	$20 per visit after Deductible
Vaccines (immunizations)	No charge (Deductible doesn't apply)
Most X-rays and lab tests	$10 per encounter after Deductible
Preventive screenings described in the *Evidence of Coverage*	$10 per encounter (Deductible doesn't apply)
Health education	$20 per individual visit (Deductible doesn't apply) No charge for group visits (Deductible doesn't apply)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	$100 per day after Deductible
Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit after Deductible
Ambulance Services	**You Pay**
Ambulance Services	$75 per trip after Deductible
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary from Plan Pharmacies:	
Generic items	$10 for up to a 100 day supply
Brand name items	$35 for up to a 100 day supply after $250 drug Deductible

Durable Medical Equipment	You Pay
Most covered durable medical equipment for home use in accord with our DME formulary up to a $2,000 calendar year benefit limit as described in the *Evidence of Coverage*	20% Coinsurance (Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric care (up to 30 days per calendar year)	$100 per day after Deductible
Outpatient visits:	
Up to a total of 20 individual and group therapy visits per calendar year	$20 per individual therapy visit after Deductible $10 per group therapy visit after Deductible
Up to 20 additional group therapy visits that meet the Medical Group criteria in the same calendar year	$10 per group therapy visit after Deductible
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *Evidence of Coverage*.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	$100 per day after Deductible
Outpatient individual therapy visits	$20 per visit after Deductible
Outpatient group therapy visits	$5 per visit after Deductible
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission after Deductible
Home Health Services	**You Pay**
Home health care (up to 100 two-hour visits per calendar year)	No charge (Deductible doesn't apply)
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge after Deductible
Hospice care	No charge (Deductible doesn't apply)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Deductibles, exclusions, or limitations, and it does not list all benefits, Copayments, and Coinsurance. For a complete explanation, please refer to the *Evidence of Coverage*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Health Plan Benefits and Coverage Matrix for the $50 Copayment Plan

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

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

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

Annual Out-of-Pocket Maximum for Certain Services	
For any one Member in the same Family Unit	$3,500 per calendar year
For an entire Family Unit of two or more Members	$7,000 per calendar year
Copayments and Coinsurance for most Services count toward this maximum as described in the *Evidence of Coverage.*	
Deductible or Lifetime Maximum	None
Coordination of Benefits	Included
Professional Services (Plan Provider office visits)	**You Pay**
Primary and specialty care visits (includes routine and Urgent Care appointments)	$50 per visit
Routine preventive physical exams	$50 per visit
Well-child preventive care visits (0–23 months)	$15 per visit
Family planning visits	$50 per visit
Scheduled prenatal care and first postpartum visit	$15 per visit
Voluntary termination of pregnancy	$50 per procedure
Eye exams	$50 per visit
Hearing tests	$50 per visit
Physical, occupational, and speech therapy visits	$50 per visit
Outpatient Services	**You Pay**
Outpatient surgery	$250 per procedure
Allergy injection visits	$5 per visit

Allergy testing visits	$50 per visit
Vaccines (immunizations)	No charge
X-rays and lab tests	$10 per encounter (except that MRI, CT, and PET are $50 per procedure)
Health education	$50 per individual visit No charge for group visits
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	$500 per day
Emergency Health Coverage	**You Pay**
Emergency Department visits	$150 per visit (does not apply if admitted directly to the hospital as an inpatient)
Ambulance Services	**You Pay**
Ambulance Services	$300 per trip
Prescription Drug Coverage	**You Pay**
Most outpatient prescription drugs are **not covered**, please refer to the *Evidence of Coverage* to learn which items are covered. The items that are covered are provided in accord with our drug formulary from Plan Pharmacies as follows:	
Generic items	$10 for up to a 100 day supply
Brand name items	$35 for up to a 100 day supply
Durable Medical Equipment	**You Pay**
Most DME items are **not covered**, please refer to the *Evidence of Coverage* to learn which items are covered	50% Coinsurance
Mental Health Services	**You Pay**
Inpatient psychiatric care (up to 30 days per calendar year)	$500 per day
Outpatient visits:	
Up to a total of 20 individual and group therapy visits per calendar year	$50 per individual therapy visit $25 per group therapy visit
Up to 20 additional group therapy visits that meet the Medical Group criteria in the same calendar year	$25 per group therapy visit

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

Chemical Dependency Services	You Pay
Inpatient detoxification	$500 per day
Outpatient individual therapy visits	$50 per visit
Outpatient group therapy visits	$5 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission
Home Health Services	**You Pay**
Home health care (up to 100 two-hour visits per calendar year)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, exclusions, or limitations, and it does not list all benefits, Copayments, and Coinsurance. For a complete explanation, please refer to the *Evidence of Coverage*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Health Plan Benefits and Coverage Matrix for the $25 Copayment Plan

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

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

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

Annual Out-of-Pocket Maximum for Certain Services	
For any one Member in the same Family Unit	$2,500 per calendar year
For an entire Family Unit of two or more Members	$5,000 per calendar year
Copayments and Coinsurance for most Services count toward this maximum as described in the *Evidence of Coverage.*	
Deductible for Certain Drugs	$250 per calendar year
Deductible for All Other Services or Lifetime Maximum	None
Coordination of Benefits	Included
Professional Services (Plan Provider office visits)	**You Pay**
Primary and specialty care visits (includes routine and Urgent Care appointments)	$25 per visit
Routine preventive physical exams	$25 per visit
Well-child preventive care visits (0–23 months)	No charge
Family planning visits	$25 per visit
Scheduled prenatal care and first postpartum visit	No charge
Voluntary termination of pregnancy	$25 per procedure
Eye exams	$25 per visit
Hearing tests	$25 per visit
Physical, occupational, and speech therapy visits	$25 per visit
Outpatient Services	**You Pay**
Outpatient surgery	$100 per procedure

Allergy injection visits	$5 per visit
Allergy testing visits	$25 per visit
Vaccines (immunizations)	No charge
X-rays and lab tests	$10 per encounter (except that MRI, CT, and PET are $50 per procedure)
Health education	$25 per individual visit No charge for group visits
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	$200 per day
Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit (does not apply if admitted directly to the hospital as an inpatient)
Ambulance Services	**You Pay**
Ambulance Services	$100 per trip
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary from Plan Pharmacies:	
Generic items	$10 for up to a 100 day supply
Brand name items	$35 for up to a 100 day supply after $250 drug Deductible
Durable Medical Equipment	**You Pay**
Most DME items are **not covered**, please refer to the *Evidence of Coverage* to learn which items are covered	20% Coinsurance
Mental Health Services	**You Pay**
Inpatient psychiatric care (up to 30 days per calendar year)	$200 per day
Outpatient visits:	
Up to a total of 20 individual and group therapy visits per calendar year	$25 per individual therapy visit $12 per group therapy visit
Up to 20 additional group therapy visits that meet the Medical Group criteria in the same calendar year	$12 per group therapy visit

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

Chemical Dependency Services	You Pay
Inpatient detoxification	$200 per day
Outpatient individual therapy visits	$25 per visit
Outpatient group therapy visits	$5 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission
Home Health Services	**You Pay**
Home health care (up to 100 two-hour visits per calendar year)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, exclusions, or limitations, and it does not list all benefits, Copayments, and Coinsurance. For a complete explanation, please refer to the *Evidence of Coverage*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Introduction

Welcome to Kaiser Permanente

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

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

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

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

About this booklet

This *Disclosure Form* summarizes some of the important features of your Kaiser Permanente membership, as well as general exclusions and limitations of your coverage. **Please read the following information so that you will know from whom or what group of providers you may obtain health care. Also, you should read this *Disclosure Form* and the *Membership Agreement* carefully if you have special health care needs.**

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Service Areas in California (the Northern or Southern California Region), which we call your "Home Region." Your Home Region is the Service Area where you are enrolled. This *Disclosure Form* describes your coverage in your Home Region. Also, this *Disclosure Form* describes different benefit plans, for example benefit plans that include Deductibles for specified Services. Everything in this section of the *Disclosure Form* applies to all benefit plans, except as otherwise indicated.

Please see the *Health Plan Benefits and Coverage Matrix* for a summary of Deductibles, Copayments, and Coinsurance. If you have questions about benefits, please call our Member Service Call Center at **1-800-464-4000** or refer to your *Membership Agreement (Agreement)*.

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

Once you become a Kaiser Permanente member, we will send you an *Agreement* with your acceptance notice. Your *Agreement* provides details about the terms and conditions of your coverage. This *Disclosure Form* is only a summary. An *Agreement* is available by calling our Member Service Call Center toll free at **1-800-464-4000** if you would like to review one before being accepted for membership.

Note: State law requires disclosure form documents to include the following notice: "Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the Kaiser Permanente Member Service Call Center at **1-800-464-4000**, to ensure that you can obtain the health care services that you need."

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

How to obtain care

Our Members receive covered medical care from Plan Providers (physicians, registered nurses, nurse practitioners, and other medical professionals) in your Home Region Service Area at Plan Facilities except as described in this *Disclosure Form* or the *Agreement* about:

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

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

Emergency Care and Post-stabilization Care from Non–Plan Providers

Emergency Care. If you have an Emergency Medical Condition, call 911 or go to the nearest hospital. When you have an Emergency Medical Condition, we cover Emergency Care anywhere in the world.

An Emergency Medical Condition is: (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs; or (2) active labor when there isn't enough time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety.

Note: For ease and continuity of care, we encourage you to go to a Plan Hospital Emergency Department listed in *Your Guidebook* if you are inside your Home Region Service Area, but only if it is reasonable to do so, considering your condition or symptoms.

Post-stabilization Care. Post-stabilization Care is the Services you receive after your treating physician determines that your Emergency Medical Condition is Clinically Stable. We cover Post-stabilization Care from a Non–Plan Provider, including inpatient care at a Non–Plan Hospital, only if we provide prior authorization for the care (prior authorization means that we must approve the Services in advance for the Services to be covered).

To request authorization to receive Post-stabilization Care from a Non–Plan Provider, you must call us at **1-800-225-8883** (TTY 711) or the notification telephone number on your ID card *before* you receive the care if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible). Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized since we do not cover unauthorized Post-stabilization Care or related transportation provided by Non–Plan Providers.

Please refer to your *Agreement* for coverage information, exclusions, and limitations.

Out-of-Area Urgent Care from Non–Plan Providers

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

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

Your identification card

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

If you need to get care before you receive your ID card, but after you have received your acceptance notice, when you make an appointment or get covered care, simply say that you are a new individual plan Member and give your medical record number and the effective date of coverage, both of which are on the acceptance notice. This information will be helpful if you need care before receiving your ID card.

Plan Facilities and *Your Guidebook*

At most of our Plan Facilities, you can usually receive all the covered Services you need, including Emergency Care, Urgent Care, specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you. For facility locations, please refer to the enclosed facility listing or call our Member Service Call Center at **1-800-464-4000**.

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

- Many Plan Facilities have a Member Services Department (refer to *Your Guidebook* for locations in your area)

Plan Medical Offices and Plan Hospitals for your area are listed in *Your Guidebook*. *Your Guidebook* describes the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. *Your Guidebook* also explains how to use our Services and make appointments, lists hours of operations, and includes a detailed telephone directory for appointments and advice. *Your Guidebook* provides other important information, such as preventive care guidelines and your Member rights and responsibilities.

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

Your primary care Plan Physician

Your primary care Plan Physician plays an important role in coordinating your medical care needs, including hospital stays and referrals to specialists. We encourage you to choose a primary care Plan Physician. You may select a primary care Plan Physician from any of our available Plan Physicians who practice in these specialties: internal medicine, family medicine, and pediatrics. Also, women can select any available primary care Plan Physician from obstetrics/gynecology. You can change your primary care Plan Physician for any reason. To learn how to select a primary care Plan Physician, please call our Member Service Call Center at **1-800-464-4000**. You can find a directory of our Plan Physicians on our Web site at **kp.org**.

Getting a referral

Referrals to Plan Providers

Primary care. Primary care Plan Physicians provide primary medical care, including pediatric care and obstetrics/gynecology care. You don't need a referral to receive primary care from Plan Physicians in the following areas: internal medicine, obstetrics/gynecology, family planning, family medicine, and pediatrics.

Specialty care. Plan Physicians who are specialists provide specialty care in areas such as surgery, orthopedics, cardiology, oncology, urology, and dermatology. A Plan Physician must refer you before you can be seen by one of our specialists except that you do not need a referral to receive care in the following areas: optometry, psychiatry, and chemical dependency. Please check *Your Guidebook* to see if your facility has other departments that don't require a referral.

Medical Group authorization procedure for certain referrals

The following Services require prior authorization by the Medical Group for the Services to be covered (prior authorization means that the Medical Group must approve the Services in advance for the Services to be covered):

- **Services not available from Plan Providers.** If your Plan Physician decides that you require covered Services not available from Plan Providers, he or she will recommend to the Medical Group that you be referred to a Non–Plan Provider inside or outside your Home Region Service Area. The appropriate Medical Group designee will authorize the Services if he or she determines that they are Medically Necessary and are not available from a Plan Provider. Referrals to Non–Plan Physicians will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your Plan Physician what Services have been authorized
- **Bariatric surgery.** If your Plan Physician makes a written referral for bariatric surgery, the Medical Group's regional bariatric medical director or his or her designee will authorize the Service if he or she determines that it is Medically Necessary. The Medical Group's criteria for determining whether bariatric surgery is Medically Necessary are described in the Medical Group's bariatric surgery referral criteria, which are available upon request
- **Durable medical equipment (DME).** If your Plan Physician prescribes a DME item, he or she will submit a written referral to the Plan Hospital's DME coordinator, who will authorize the DME item if he or she determines that your DME coverage includes the item and that the item is listed on our formulary for your condition. If the item doesn't appear to meet our DME formulary guidelines, then the DME coordinator will contact the Plan Physician for additional information. If the DME request still doesn't appear to meet our DME formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our DME formulary, please refer to the *Agreement*

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

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

Second opinions

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

How Plan Providers are paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians

are paid to provide or arrange medical and hospital care for Members, please ask your Plan Physician or call our Member Service Call Center at **1-800-464-4000**.

Your costs

Cost Sharing (Deductibles, Copayments, and Coinsurance)

When you receive covered Services, you must pay your Cost Sharing amount as described in your *Agreement* at the time you receive the Services.

For items ordered in advance, you may have to pay the Cost Sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Sharing before the item is ordered.

Note: In some cases, we may agree to bill you for your Cost Sharing amount, and if we do we will add a $13.50 billing fee and send you a bill for the entire amount. This $13.50 billing fee will not count toward any Deductible or the annual out-of-pocket maximum.

Copayments and Coinsurance. A summary of Copayments and Coinsurance is listed in the *Health Plan Benefits and Coverage Matrix*. Please refer to the "Benefits and Cost Sharing" section of your *Agreement* for the complete list of Copayments and Coinsurance.

Deductibles. If your coverage includes Deductibles, you must pay Charges for certain covered Services subject to the Deductible until you meet the Deductible each calendar year. After you meet the Deductible and for the remainder of that calendar year, you pay the applicable Copayment or Coinsurance subject to the annual out-of-pocket maximum. The only payments that count toward a Deductible are those you make for covered Services that are subject to the Deductible, but only if the Service would otherwise be covered. When you pay a Deductible amount for a Service, we will give you a receipt. We will also send you a statement summarizing the amounts you have paid toward your Deductible and reaching the annual out-of-pocket maximum. You can also obtain a copy of this statement from our Deductible Products Service Team at **1-800-390-3507**.

Please refer to the *Health Plan Benefits and Coverage Matrix* to learn if your coverage is subject to a Deductible and the amount of the Deductible. Please refer to your *Agreement* for more information about Deductibles.

Annual out-of-pocket maximum

There is a limit to the total amount of Deductibles, Copayments, and Coinsurance you must pay in a calendar year for certain Services you receive in the same calendar year, which are listed in your *Agreement*. The limit amounts are specified in the *Health Plan Benefits and Coverage Matrix*.

If you enroll in a Deductible Plan, we will send you a monthly statement of the amounts you have paid, including the amount you have paid toward reaching your annual out-of-pocket maximum. If you are not enrolled in a Deductible Plan, ask for and keep the receipt when you pay for one of the Services listed in your *Agreement* that count toward reaching the annual out-of-pocket maximum. When the receipts add up to the annual out-of-pocket maximum, please call our Member Service Call Center at **1-800-464-4000** to find out where to turn in your receipts. When you turn them in, we will give you a document stating that you do not have to pay any more Copayments or Coinsurance for the specified Services through the end of the calendar year.

Payment of Premiums

You must prepay Premiums listed on the enclosed rate chart, applicable to your coverage, for each month on or before the last day of the preceding month. Only Members for whom we have received the appropriate Premiums are entitled to coverage, and then only for the period for which we have received payment.

Financial liability

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

Reimbursement for Emergency, Post-stabilization, or Out-of-Area Urgent Care

If you receive Emergency Care, Post-stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider, you must pay for the Services unless the Non–Plan Provider agrees to bill us. If you want us to pay for the Services you

must file a claim. We will reduce any payment we make to you or the Non–Plan Provider by applicable Cost Sharing.

To file a claim, this is what you need to do:

- As soon as possible, request our claim form by calling our Member Service Call Center at **1-800-464-4000** or **1-800-390-3510** (TTY 1-800-777-1370). One of our representatives will be happy to assist you if you need help completing our claim form
- If you have paid for the Services, you must send us our completed claim form for reimbursement. Please attach any bills and receipts from the Non–Plan Provider
- To request that a Non–Plan Provider be paid for Services, you must send us our completed claim form and include any bills from the Non–Plan Provider. If the Non–Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the Non–Plan Provider for covered Services other than your Cost Sharing amount, please call our Member Service Call Center at **1-800-390-3510** for assistance
- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled. For example, we may require documents such as travel documents or original travel tickets to validate your claim

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

Termination of benefits

You may terminate your membership 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 the *Agreement*, including Premiums, for the period prior to your termination date.

For Northern California Region Members:
Kaiser Permanente
California Service Center
P.O. Box 23059
San Diego, CA 92193-3059

For Southern California Region Members:
Kaiser Permanente
California Service Center
P.O. Box 23127
San Diego, CA 92193-3127

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

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

- The *Agreement* between you and Health Plan is terminated for any reason
- You are no longer eligible for coverage as described in your *Agreement*
- You commit one of the following acts, in which case we will send the Subscriber written notice and the termination will be effective on the date we send the notice (you will not be allowed to enroll in Health Plan in the future):
    - ♦ your behavior threatens the safety of Plan personnel or of any person or property at a Plan Facility
    - ♦ you commit theft from Health Plan, from a Plan Provider, or at a Plan Facility
    - ♦ you knowingly commit fraud in connection with membership, Health Plan, or a Plan Provider
- You fail to pay us the appropriate Premiums for your Family Unit. Persons terminated for nonpayment may not enroll in Health Plan even after paying all amounts owed unless we approve the enrollment. Also, you must pass a medical review unless we reinstate your membership without a lapse in coverage

Rescission of membership

In order for us to accept you for enrollment, you must meet eligibility requirements and pass a medical review of the health information you provided in your enrollment application.

If, at any time, we determine that you or someone on your behalf intentionally gave us incomplete or incorrect material information in the enrollment process and our decision to accept your enrollment was based, in whole or in part, on the misinformation, we will rescind your membership (rescind means we will completely void your membership so that no coverage ever existed).

If we rescind your membership, we will send written notice to the Subscriber. We will explain the basis for our decision and how you can appeal the decision. You will be required to pay as a non-Member for any Services we covered. Within 30 days, we will refund all applicable Premiums except that we may subtract any amounts you owe us.

Please refer to the *Agreement* for more information.

Individual continuation of benefits for Dependents

If you no longer qualify as a Dependent, you may be eligible to enroll as a Subscriber without passing medical review by applying within 31 days after your coverage ends.

Getting assistance

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

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

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

Dispute resolution and binding arbitration

Member Service representatives at our Plan Facilities or Member Service Call Center can help you with unresolved issues. They can also help you file a grievance orally or in writing. You can also submit a grievance electronically at **kp.org**. You must submit your grievance within 180 days of the date of the incident.

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

Except for small claims court cases, any dispute between Members, their heirs, or associated parties (on the one hand) and Health Plan, its health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising from your Health Plan membership, must be decided through binding arbitration. This includes claims for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, Services, regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration.

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

Renewal provisions

If you comply with all of the terms of the *Agreement*, we will offer to renew the *Agreement* effective January 1, 2007, upon 30 days prior written notice to the Subscriber. The *Agreement* generally changes each year, or sooner if required by law. The Subscriber will be given 30 days notice of any changes, including Premiums and benefits.

Principal exclusions, limitations, and reductions of benefits

Exclusions

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

- Care in a licensed intermediate care facility, except for covered hospice care
- Chiropractic Services, unless otherwise stated in your *Agreement*
- Artificial insemination, unless otherwise stated in your *Agreement*, and conception by artificial means
- Cosmetic Services, except for Services covered under "Reconstructive Surgery" and "Prosthetic and Orthotic Devices" in the *Agreement*
- Custodial care, except for covered hospice care
- Dental care and dental X-rays
- Disposable supplies for home use, such as diapers, underpads, and other incontinence supplies, bandages, gauze, tape, antiseptics, dressings, and Ace-type bandages
- Experimental or investigational Services, except as required by law for certain cancer clinical trials. You can request an independent medical review if you disagree with our decision to deny treatment because it is experimental or investigational (please refer to the *Agreement* for details about independent medical review and other dispute resolution options)
- Eyeglasses, contact lenses, and contact lens eye examinations, unless otherwise stated in your *Agreement*

- Services related to eye surgery or orthokeratologic Services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism
- Hearing aids, unless otherwise stated in your *Agreement*
- Physical examinations related to employment, insurance, licensing, court orders, parole, or probation, unless a Plan Physician determines that the Services are Medically Necessary
- Routine foot care Services that are not Medically Necessary
- Services related to conception, pregnancy, or delivery in connection with a surrogacy arrangement, except for otherwise-covered Services provided to a Member who is a surrogate
- Services related to the diagnosis and treatment of infertility, unless otherwise stated in your *Agreement*
- Services related to a noncovered Service, except for Services we would otherwise cover to treat complications of the noncovered Service
- Speech therapy Services to treat social, behavioral, or cognitive delays in speech or language development, unless Medically Necessary
- Transgender surgery
- Travel and lodging expenses
- Treatment of hair loss or growth

Limitations

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

Also, additional limitations that apply only to a particular Service are listed in the description of that Service in the benefit description in your *Agreement*.

Reductions

If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered Services, you must pay us Charges for those Services, except that the amount you must pay will not exceed the maximum amount allowed under California Civil Code Section 3040. Note: This "Reductions" section does not affect your obligation to pay Cost Sharing for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph. Alternatively, we may file a subrogation claim on our own behalf against the third party. In addition to these third party liability claims by Kaiser Permanente, the contracts between Kaiser Permanente and some providers may allow these providers to collect all or a portion of the difference between Kaiser Permanente's Charges and the fees the provider charges to the general public for the Services you received.

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

To become a Member

We look forward to welcoming you as a Member. To apply for Kaiser Permanente Individuals and Families plan membership, simply return a Health Plan application and medical review form for each Member of your Family Unit. Each person listed on the application must submit medical review information. If we approve your application, we will notify you of the date your coverage will begin and you can begin using our Services on the effective date of coverage indicated in our acceptance notice. Often, the effective date is the first day of the month following the date when we approve your application. Again, if you have any questions about Kaiser Permanente, please call our Member Service Call Center toll free at **1-800-464-4000**.

Who may apply

Each person requesting enrollment must pass our medical review to enroll. Also, when a Subscriber enrolls, he or she must live in our Northern or Southern California Regions' Service Area. The Service Area where the Subscriber enrolls is your Home Region. In addition, if you are the Subscriber, the following persons are eligible to enroll as your Dependents:

- Your Spouse. For the purposes of this *Disclosure Form*, the term "Spouse" includes your registered domestic partner who meets all the requirements of Section 297 of the California Family Code, or your domestic partner as determined by Health Plan

- Your or your Spouse's unmarried children (including adopted children or children placed with you for adoption) who are under age 19
- Other unmarried dependent persons (but not including foster children) who meet all of the following requirements:
    - ♦ they are under age 19
    - ♦ they receive all of their support and maintenance from you or your Spouse
    - ♦ they permanently reside with you (the Subscriber)
    - ♦ you or your Spouse is the court-appointed guardian (or was before the person reached age 18) or the person's parent is an enrolled Dependent under your family coverage
- Dependents who meet the Dependent eligibility requirements, except for the age limit, may be eligible if they meet all the following requirements:
    - ♦ they are incapable of self-sustaining employment because of mental retardation or physical handicap that occurred prior to age 19
    - ♦ they receive substantially all of their support and maintenance from you or your Spouse
    - ♦ you give us proof of their incapacity and dependency within 31 days after we request it

Note: Medical review considers the health information you provide in your enrollment application.

Persons barred from enrolling

- You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause
- Persons who have had entitlement to receive Services through Health Plan terminated twice in any 12-month period for failure to pay individual (nongroup) plan premiums cannot enroll for 12 months after the second termination date. For the purposes of this paragraph, a termination does not count if we reinstated your entitlement to receive Services because you made full payment on or before the next scheduled payment due date following the one you missed

Miscellaneous notices

Termination of a Plan Provider's contract

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

Completion of Services

If you are currently receiving covered Services in one of the following cases 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:

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

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

- Your Health Plan coverage is in effect on the date you receive the Service
- You are receiving Services in one of the cases listed above from the terminated Plan Provider on the provider's termination date
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside your Home Region Service Area
- The Services to be provided to you would be covered Services under the *Agreement* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from the termination date of the Plan Provider

The Cost Sharing for completion of Services are the same as those required for Services provided by a Plan Provider as described in the *Agreement*. **For more information about this provision and to request the Services or a copy of our "Completion of Covered Services" policy, please call our Member Service Call Center.**

Drug formulary

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

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

grievance as described in the *Agreement*. Also, our formulary guidelines may require you to participate in a Medical Group–approved behavioral intervention program for specific conditions, and you may be required to pay for the program.

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

Health Insurance Counseling and Advocacy Program (HICAP)

For additional information concerning covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number, 1-800-434-0222 (TTY 711), for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

Not federally qualified

This plan is not a federally qualified health benefit plan.

Privacy practices

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

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

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

Special note about Medicare

The information contained in this booklet is not applicable for most Medicare beneficiaries. If you are or become eligible for Medicare, you may be eligible to enroll in Kaiser Permanente Senior Advantage.

Definitions

Charges: Charges means the following:

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

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

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

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

Cost Sharing: The amount you are required to pay for a covered Service, for example, a Deductible, Copayment, or Coinsurance.

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

Dependent: A Member who meets the eligibility requirements as a Dependent as described in the *Agreement*.

Emergency Care: Emergency Care is:

- Evaluation by a physician (or other appropriate personnel under the supervision of a physician to the extent provided by law) to determine whether you have an Emergency Medical Condition
- Medically Necessary Services required to make you Clinically Stable within the capabilities of the facility
- Emergency ambulance Services covered under "Ambulance Services" in the *Agreement*

Emergency Medical Condition: An Emergency Medical Condition is (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs; or (2) active labor when there isn't enough time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety.

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

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

Home Region: Health Plan's Northern California Region or Southern California Region where you are enrolled.

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

Medical Group: For Northern California Region Members, The Permanente Medical Group, Inc., a for-profit professional corporation, and for Southern California Region Members, the Southern California Permanente Medical Group, a for-profit professional partnership.

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

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

Member: A person who is eligible and enrolled, and for whom we have received applicable Premiums. This *Disclosure Form* sometimes refers to a Member as "you."

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

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

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

Out-of-Area Urgent Care: An Urgent Care need requires prompt medical attention, but is not an Emergency Medical Condition. Out-of-Area Urgent Care is Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

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

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

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

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

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

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

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that we designate as a Plan Provider in your Home Region Service Area.

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

Premiums: Periodic membership charges paid by or on behalf of each Member. Premiums are in addition to any Cost Sharing.

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

Service Area: For Members enrolled in the **Northern California Region**, the following counties are entirely inside our Northern California Region Service Area: Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus. Also, portions of the following counties are

inside our Northern California Region Service Area, as indicated by the ZIP codes below for each county:

- Amador: 95640, 95669
- El Dorado: 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762
- Fresno: 93242, 93602, 93606-07, 93609, 93611-13, 93616, 93618-19, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-30, 93740-41, 93744-45, 93747, 93750, 93755, 93760-61, 93764-65, 93771-80, 93784, 93786, 93790-94, 93844, 93888
- Kings: 93230, 93232, 93242, 93631, 93656
- Madera: 93601-02, 93604, 93614, 93623, 93626, 93636-39, 93643-45, 93653, 93669, 93720
- Mariposa: 93601, 93623, 93653
- Napa: 94503, 94508, 94515, 94558-59, 94562, 94567*, 94573-74, 94576, 94581, 94589, 94599, 95476
- Placer: 95602-04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95692, 95703, 95722, 95736, 95746-47, 95765
- Santa Clara: 94022-24, 94035, 94039-43, 94085-89, 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, 95101-03, 95106, 95108-42, 95148, 95150-61, 95164, 95170-73, 95190-94, 95196
- Sonoma: 94515, 94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999, 95401-09, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, 95492
- Sutter: 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95837
- Tulare: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- Yolo: 95605, 95607, 95612, 95616-18, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99
- Yuba: 95692, 95903, 95961

*Exception: Knoxville is not in the Northern California Region Service Area.

For Members enrolled in the **Southern California Region**, Orange County is entirely inside our Southern California Region Service Area. Also, portions of the following counties are inside our Southern California Region Service Area, as indicated by the ZIP codes below for each county:

- Imperial: 92274-75
- Kern: 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93250-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380-90, 93501-02, 93504-05, 93518-19, 93531, 93536, 93560-61, 93581
- Los Angeles: 90001-84, 90086-89, 90091, 90093-96, 90099, 90101-03, 90189, 90201-02, 90209-13, 90220-24, 90230-33, 90239-42, 90245, 90247-51, 90254-55, 90260-67, 90270, 90272, 90274-75, 90277-78, 90280, 90290-96, 90301-13, 90397-98, 90401-11, 90501-10, 90601-10, 90612, 90623, 90630-31, 90637-40, 90650-52, 90659-62, 90665, 90670-71, 90701-03, 90706-07, 90710-17, 90723, 90731-34, 90744-49, 90755, 90801-10, 90813-15, 90822, 90831-35, 90840, 90842, 90844-48, 90853, 90888, 90899, 91001, 91003, 91006-07, 91009-12, 91016-17, 91020-21, 91023-25, 91030-31, 91040-43, 91046, 91066, 91077, 91101-10, 91114-18, 91121, 91123-26, 91129, 91131, 91182, 91184-85, 91187-89, 91191, 91199, 91201-10, 91214, 91221-22, 91224-26, 91301-13, 91316, 91321-22, 91324-31, 91333-35, 91337, 91340-46, 91350-57, 91361-65, 91367, 91371-72, 91376, 91380-91388, 91390, 91392-96, 91399, 91401-13, 91416, 91423, 91426, 91436, 91470, 91482, 91495-97, 91499, 91501-08, 91510, 91521-23, 91526, 91601-12, 91614-18, 91702, 91706, 91709, 91711, 91714-16, 91722-24, 91731-35, 91740-41, 91744-50, 91754-56, 91759, 91765-73, 91775-76, 91778, 91780, 91788-93, 91795, 91797, 91799, 91801-04, 91841, 91896, 91899, 93243, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93560, 93563, 93584, 93586, 93590-91, 93599
- Riverside: 91752, 92201-03, 92210-11, 92220, 92223, 92230, 92234-36, 92240-41, 92247-48, 92253-55, 92258, 92260-64, 92270, 92274, 92276, 92282, 92292, 92320, 92324, 92373, 92399, 92501-09, 92513-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92595-96, 92599, 92860, 92877-83
- San Bernardino: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758, 91761-64, 91766, 91784-86, 91792, 91798, 92252, 92256, 92268, 92277-78, 92284-86, 92305, 92307-08, 92313-18, 92321-22, 92324-26, 92329, 92331, 92333-37, 92339-41, 92344-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-95, 92397, 92399, 92401-08, 92410-15, 92418, 92423-24, 92427, 92880
- San Diego: 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-47, 91950-51, 91962-63, 91976-80, 91987, 91990, 92007-11, 92013-14, 92018-27, 92029-30,

92033, 92037-40, 92046, 92049, 92051-52, 92054-58, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-85, 92090-93, 92096, 92101-24, 92126-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-79, 92182, 92184, 92186-87, 92190-99

- Ventura: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07, 93009, 93010-12, 93015-16, 93020-21, 93022, 93030-36, 93040, 93041-44, 93060-61, 93062-66, 93093-94, 93099, 93252

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

Services: Health care services or items.

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and for whom we have received applicable Premiums.

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

NOTES