**102095 Pepperdine University**

# Disclosure Form Part One — Principal Benefits for Kaiser Permanente Traditional Plan (9/1/07—8/31/08)

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

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Southern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*) 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 Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year after the Copayments and Coinsurance you pay for those Services add up to one of the following amounts: | |
| For self-only enrollment (a Family Unit of one Member) | $1,500 per calendar year |
| For any one Member in a Family Unit of two or more Members | $1,500 per calendar year |
| For an entire Family Unit of two or more Members | $3,000 per calendar year |
| **Deductible or Lifetime Maximum** | None |
| **Professional Services (Plan Provider office visits)** | **You Pay** |
| Primary and specialty care visits (includes routine and Urgent Care appointments) | $15 per visit |
| Routine preventive physical exams | $15 per visit |
| Well-child preventive care visits (0–23 months) | No charge |
| Family planning visits | $15 per visit |
| Scheduled prenatal care and first postpartum visit | No charge |
| Routine preventive refraction exams | $15 per visit |
| Routine preventive hearing tests | $15 per visit |
| Physical, occupational, and speech therapy visits | $15 per visit |
| **Outpatient Services** | **You Pay** |
| Outpatient surgery | $15 per procedure |
| Allergy injection visits | No charge |
| Allergy testing visits | $15 per visit |
| Vaccines (immunizations) | No charge |
| X-rays and lab tests | No charge |
| Health education: | |
| Individual visits | $15 per visit |
| Group educational programs | No charge |
| **Hospitalization Services** | **You Pay** |
| Room and board, surgery, anesthesia, X-rays, lab tests, and drugs | No charge |
| **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 | No charge |
| **Prescription Drug Coverage** | **You Pay** |
| Most covered outpatient items in accord with our drug formulary guidelines from Plan Pharmacies or from our mail-order program: | |
| Generic items | $10 for up to a 100-day supply |
| Brand-name items | $20 for up to a 100-day supply |
| **Durable Medical Equipment (DME)** | **You Pay** |
| Most covered DME for home use in accord with our DME formulary guidelines | 20% Coinsurance |
| **Mental Health Services** | **You Pay** |
| Inpatient psychiatric care (up to 45 days per calendar year) | No charge |

*continued*

| **Mental Health Services** | **You Pay** |
|---|---|
| Outpatient visits: | |
| Up to a total of 20 individual and group visits per calendar year | $15 per individual visit<br>$7 per group visit |
| Up to 20 additional group visits that meet the Medical Group criteria in the same calendar year | $7 per group visit |
| Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the *EOC*. | |

| **Chemical Dependency Services** | **You Pay** |
|---|---|
| Inpatient detoxification | No charge |
| Outpatient individual visits | $15 per visit |
| Outpatient group 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 visits per calendar year) | No charge |

| **Other** | **You Pay** |
|---|---|
| Hearing aid(s) every 36 months | Amount in excess of $2,500 Allowance per aid |
| 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, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

# YOUR COVERAGE

Disclosure Form Part Two for Kaiser Permanente Traditional Plan and Deductible Plan

## Contents



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### Member Service Call Center

Weekdays 7 a.m.–7 p.m., weekends 7 a.m.–3 p.m. (except holidays)

**1-800-464-4000** toll free

**1-800-777-1370** toll free (TTY for the hearing/speech impaired)

# Introduction

## Welcome to Kaiser Permanente

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

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

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

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

## About this booklet

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

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Service Areas in California (the Northern California or Southern California Region), which we call your "Home Region." Please refer to *Your Benefits (Disclosure Form Part One)* to learn which California Region is your Home Region. 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 *Your Benefits (Disclosure Form Part One)* for a summary of Deductibles, Copayments, and Coinsurance. If you have questions about benefits, please call our Member Service Call Center toll free at **1-800-464-4000** or refer to your *Evidence of Coverage.*

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

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

**Note:** State law requires disclosure form documents to include the following notice: "Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception;

sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the Kaiser Permanente Member Service Call Center toll free 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) inside your Home Region's Service Area at Plan Facilities except as described in this *Disclosure Form* or the *Evidence of Coverage* for the following Services listed below:

- Authorized referrals
- Emergency ambulance Services
- Emergency Care, Post-stabilization Care, and Out-of-Area Urgent Care
- Hospice care

For Plan Facility locations, please refer to the enclosed facility listing, *Your Guidebook to Kaiser Permanente Services,* 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's 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 toll free at **1-800-225-8883** (TTY users call **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 *Evidence of Coverage* 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's 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's 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. When you get care, please bring your Kaiser Permanente ID and a photo ID. Your medical record number is used to identify your medical records and membership information. Your medical record number should never change. Please call our Member Service Call Center if we ever inadvertently issue you more than one medical record number or if you need to replace your Kaiser Permanente ID card.

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

## Plan Facilities and *Your Guidebook to Kaiser Permanente Services*

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 toll free 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 toll free at **1-800-464-4000** or **1-800-777-1370** (TTY for the deaf, hard of hearing, or speech impaired), weekdays 7 a.m. to 7 p.m. and weekends 7 a.m. to 3 p.m. (except holidays). 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 toll free 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, family medicine, obstetrics/gynecology, family planning, 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's 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 you are a Southern California Region Member and 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 *Evidence of Coverage*
- **Ostomy and urological supplies.** If your Plan Physician prescribes ostomy or urological supplies, he or she will submit a written referral to the Plan Hospital's designated coordinator, who will authorize the item if he or she determines that it is covered and the item is listed on our soft goods formulary for your condition. If the item doesn't appear to meet our soft goods formulary guidelines, then the coordinator will contact the Plan Physician for additional information. If the request still doesn't appear to meet our soft goods formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our soft goods formulary, please refer to the *Evidence of Coverage*
- **Transplants.** If your Plan Physician makes a written referral for a transplant, the Medical Group's regional transplant advisory committee or board (if one exists) will authorize the Services if it determines that they are Medically Necessary. In cases where no transplant committee or board exists, the Medical Group will refer you to physician(s) at a transplant center, and the Medical Group will authorize the Services if the transplant center's physician(s) determine that they are Medically Necessary. Note: A Plan Physician may provide or authorize a corneal transplant without using this Medical Group transplant authorization procedure

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

## Second opinions

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

## 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 toll free 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 *Evidence of Coverage* 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.

### Copayments and Coinsurance

A summary of Copayments and Coinsurance is listed in *Your Benefits (Disclosure Form Part One)*. Please refer to the "Benefits and Cost Sharing" section of your *Evidence of Coverage* 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. If you are a Member in a Family Unit of two or more Members, you reach the Deductible either when you meet the Deductible for any one Member, or when your Family Unit reaches the Family Unit Deductible. Each other member in your Family Unit must continue to pay Charges during the calendar year until either he or she reaches the Deductible for any one Member in a Family Unit of two or more Members, or your Family Unit reaches the Family Unit Deductible.

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 *Your Benefits (Disclosure Form Part One)* to learn if your coverage is subject to a Deductible and the amount of the Deductible. Please refer to your *Evidence of Coverage* for more information about Deductibles.

### Annual out-of-pocket maximum

There is a limit to the total amount of Cost Sharing you must pay in a calendar year for certain Services you receive in the same calendar year, which are listed in your *Evidence of Coverage*. The limit amounts are specified in *Your Benefits (Disclosure Form Part One)*. If you are a Member in a Family Unit of two or more Members, you reach the annual out-of-pocket maximum either when you meet the maximum for any one Member, or when your Family Unit reaches the Family Unit maximum. Please refer to your *Evidence of Coverage* for more information about annual out-of-pocket maximums.

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 *Evidence of Coverage* 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 toll free 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 Cost Sharing for the specified Services through the end of the calendar year.

### Payment of Premiums

Your group is responsible for paying Premiums. If you are responsible for any contribution to the Premiums, your group will tell you the amount and how to pay your group (through payroll deduction, for example).

### 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 "Completion of Services from Non–Plan Providers" 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 toll free at **1-800-464-4000** or **1-800-390-3510** (TTY users call **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 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 toll free 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 *Evidence of Coverage* for additional instructions, coverage information, exclusions, limitations, and dispute resolution for denied claims.

## Termination of benefits

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

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

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

- The contract between your group and Kaiser Permanente is terminated for any reason
- You are no longer eligible for group coverage as described in your *Evidence of Coverage*
- You commit one of the following acts, we may terminate your membership immediately by sending written notice to the Subscriber, termination will be effective on the date we send the notice, and you will not be allowed to enroll in Health Plan in the future:
  - your behavior threatens the safety of Kaiser Permanente 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 intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider
- Your group fails to pay us the appropriate Premiums for your Family Unit

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

## Continuation of membership

### Continuation of group coverage

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

If at any time you become entitled to continuation of group coverage such as Cal-COBRA, please examine your coverage options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely. Note: Medical history does not impact premiums or eligibility for our individual plan described under "Converting from group membership to an individual plan" in this section. However, the individual plan premiums and coverage are different from the premiums and coverage under your group plan.

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

### Converting from group membership to an individual plan

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

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

## Getting assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your primary care Plan

Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Call Center representatives are available to assist you weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays) toll free at **1-800-464-4000** or **1-800-777-1370** (TTY for the deaf, hard of hearing, or 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 toll free at **1-888-HMO-2219** for assistance.

Except for Small Claims Court cases and, if your group must comply with Employee Retirement Income Security Act (ERISA), certain benefit-related disputes, any dispute between Members, their heirs, or associated parties (on the one hand) and Health Plan, its health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising from your Health Plan membership, must be decided through binding arbitration. This includes claims for medical or hospital malpractice (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 *Evidence of Coverage* for more information, including the complete arbitration provision.

## Renewal provisions

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

## Principal exclusions, limitations, and reductions of benefits

### Exclusions

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

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

Additional limitations that apply only to a particular benefit are listed in the description of that benefit in your *Evidence of Coverage*.

### 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 recover all or a portion of the difference between the fees paid by Kaiser Permanente and the fees the provider charges to the general public for the Services you received.

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

## To become a Member

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

## Miscellaneous notices

### Completion of Services from Non–Plan Providers

**New Member.** If you are currently receiving Services from a Non–Plan Provider in one of the cases listed below under "Eligibility" and your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective, you may be eligible for limited coverage of that Non–Plan Provider's Services.

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

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

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends

- We may cover Services for serious chronic conditions until the earlier of (i) 12 months from your membership effective date if you are a new Member; (ii) 12 months from the termination date of the terminated provider; or (iii) the first day after a course of treatment is complete, when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - it persists without full cure
  - it worsens over an extended period of time
  - it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Care for children under age 3. We may cover completion of these Services until the earlier of (i) 12 months from the child's membership effective date if the child is a new Member; (ii) 12 months from the termination date of the terminated provider; or (iii) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your membership effective date if you are a new Member or within 180 days of the termination date of the terminated provider

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

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

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