KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Southern California Region

A nonprofit corporation

Kaiser Permanente Deductible HMO Plan
Combined Disclosure Form and Evidence of Coverage for
A-STAR STAFFING, INC

Kaiser Permanente Silver 70 HMO 1000/50 + Child Dental Alt
Group ID: 340494 *EOC* Number: 1

January 1, 2017, through December 31, 2017

Member Service Contact Center
24 hours a day, seven days a week (except closed holidays)
1-800-464-4000 (TTY users call **711**)
kp.org

Language Assistance Services

English: We provide interpreter services at no cost to you, 24 hours a day, 7 days a week, during all hours of operation. You can have an interpreter help answer your questions about our health care coverage. You can also request materials translated in your language at no cost to you. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: نؤمن خدمات الترجمة الفورية مجانًا لك على مدار الساعة كافة أيام الأسبوع طوال ساعات العمل. بإمكانك طلب مساعدة المترجم الفوري للإجابة على كافة أسئلتك حول التغطية الصحية التي نقدمها. بالإضافة إلى ذلك، يمكنك طلب ترجمة الوثائق الطبية للغتك مجانًا. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمة الهاتف النصي يرجي الاتصال على الرقم **(711)**.

Armenian: Մենք օրը 24 ժամ, շաբաթը 7 օր, մեր աշխատանքի բոլոր ժամերին Ձեզ համար անվճար բանավոր թարգմանչի ծառայություններ ենք տրամադրում: Թարգմանչի օգնությամբ Դուք կարող եք պատասխան ստանալ Ձեր հարցերին՝ մեր կողմից տրամադրվող առողջության ապահովագրության վերաբերյալ: Կարող եք նաև Ձեր լեզվով թարգմանված գրավոր նյութեր խնդրել, որոնք Ձեզ համար անվճար են: Պարզապես զանգահարեք մեզ՝ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ՝ շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711** համարով:

Farsi: ما خدمات مترجم شفاهی را در 24 ساعت شبانروز و 7 روز هفته در طول همه ساعات کاری بدون اخذ هزینه در اختیار شما قرار می دهیم. شما می توانید برای کمک در پاسخگویی به سؤالات خود در مورد پوشش مراقبت درمانی ما از یک مترجم شفاهی بهره مند شوید. همچنین می توانید درخواست کنید که همه جزوات بدون اخذ هزینه به زبان شما ترجمه شوند. کافیست در 24 ساعت شبانروز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران TTY با شماره **711** تماس بگیرند

Hindi: हम संचालन के सभी घंटों के दौरान आपको बिना किसी लागत के दुभाषिया सेवाएँ, दिन के **24** घंटे, सप्ताह के सातों दिन प्रदान करते हैं। आप हमारी स्वास्थ्य देखभाल कवरेज के बारे में आपके प्रश्नों के जवाब के लिए एक दुभाषिये की सहायता ले सकते हैं। आप बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए अनुरोध भी कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दिन के **24** घंटे,

Hmong: Peb muaj neeg txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub ib lim tiam twg, thawm cov sij hawm qhib ua lag luam.Koj muaj tau ib tug neeg txhais lus los pab teb koj cov lus nug txog peb cov kev pab them nqi kho mob.Koj thov tau kom muab cov ntaub ntawv txhais uas koj hom lus pub dawb rau koj.Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu **711**.

Japanese:
当院では、全診療時間を通じて、通訳サービスを無料で、年中無休、終日ご利用いただけます。当院の医療内容についてのご質問および回答には、通訳がお手伝いいたします。また、日本語に翻訳された資料を無料で請求できます。お気軽に**1-800-464-4000**までお電話ください（祭日を除き年中無休）。TTYユーザーは**711**にお電話ください。

Khmer: យើងផ្តល់សេវានៃអ្នកបកប្រែដោយឥតអស់ថ្លៃដល់អ្នកឡើយ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ ក្នុងអំឡុងម៉ោងធ្វើការទាំងអស់។ អ្នកអាចមានអ្នកបកប្រែ ដើម្បីជួយឆ្លើយសំណួររបស់អ្នក អំពី ការរ៉ាប់រងថែទាំសុខភាព របស់យើង។ អ្នកក៏អាចស្នើសុំសំការៈដែលបានបកប្រែជាភាសាខ្មែរ ដោយឥតអស់ថ្លៃដល់អ្នកដែរ។ គ្រាន់តែទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ **711** ។

Korean: 업무 시간 동안에는 요일 및 시간에 관계없이 통역 서비스를 무료로 이용하실 수 있습니다. 통역의도움을받아 건강 보험 혜택에 관하여 질문하고 답변을 들으실 수 있습니다. 또한, 귀하가 사용하는 언어로 번역된 자료를 요청해 무료로 제공받으실 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000**번으로 전화해 문의하십시오(공휴일 휴무). TTY 사용자 번호 **711**.

Navajo: Nihí ata' halne'é áká'adoolwołígíí nihei hóló t'áá jíík'é, t'áá naadiin dį́į' ahéé'iilkeedgo, tsosts'id yiskąą́jį', ndá'anishgo oolkił biyi' góné. Ata' halne'é niká'adoolwoł na'ídikid nee hóló́ógo díí ats'íís baa áháyą́ą bik'éstí'ígíí biná'ídiłkidgo. Áádóó ałdó' naaltsoos lá t'áá ní nizaad k'ehji álnéehgo t'áá jíík'é ádoolníił. Nihích'i' hodíílnih kojį' **1-800-464-4000** jį́į́go dóó tł'ée' nidi, tsosts'id yiskąą́jį' dimoo na'adleehjį' (Holidaysgo éí da'deelkaal) doo da'diits'a'ígíí chodayool'į́nígíí kojį' hodíílnih **711**

Punjabi: ਅਸੀਂ ਕਾਰਵਾਈ ਦੇ ਸਾਰੇ ਘੰਟਿਆਂ ਦੇ ਦੌਰਾਨ, ਤੁਹਾਨੂੰ ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ, ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਮੁਹੱਈਆ ਕਰਵਾਉਂਦੇ ਹਾਂ। ਤੁਸੀਂ ਸਾਡੀ ਸਿਹਤ ਦੇਖਭਾਲ ਕਵਰੇਜ ਬਾਰੇ ਆਪਣੇ ਸਵਾਲਾਂ ਦੇ ਜਵਾਬ ਲਈ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲੈ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਦੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਬਸ ਸਿਰਫ਼ ਸਾਨੂੰ **1-800-464-4000** ਤੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫ਼ੋਨ ਕਰੋ। TTY ਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711** 'ਤੇ ਫ਼ੋਨ ਕਰਨ।

Russian: Мы всегда в часы работы обеспечиваем Вас услугами устного переводчика, 24 часа в сутки, 7 дней в неделю. Чтобы получить ответы на свои вопросы о нашем страховом покрытии услуг здравоохранения, Вы можете воспользоваться помощью устного переводчика. Вы также можете запросить бесплатный перевод материалов на Ваш язык. Просто позвоните нам по телефону **1-800-464-4000**, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру **711**.

Spanish: Ofrecemos servicios de traducción al español sin costo alguno para usted durante todo el horario de atención, 24 horas al día, siete días a la semana. Puede contar con la ayuda de un intérprete para responder las preguntas que tenga sobre nuestra cobertura de atención médica. Además, puede solicitar que los materiales se traduzcan a su idioma sin costo alguno. Solo llame al

Tagalog: May magagamit na mga serbisyo ng tagasalin ng wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo, sa lahat oras ng trabaho. Makakatulong ang tagasalin ng wika sa pagsagot sa mga tanong mo tungkol sa iyong coverage sa pangangalagang pangkalusugan. Maaari kang humingi ng mga babasahin na isinalin sa iyong wika nang wala kang babayaran. Tawagan lamang kami sa **1-800-464-4000**, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa **711**.

Thai: เรามีบริการล่ามฟรีสำหรับคุณตลอด 24 **ชั่วโมง ทุกวัน ตลอดชั่วโมงทำการของเราคุณสามารถขอให้ล่ามช่วยตอบคำถามของคุณที่เกี่ยวกับความคุ้มครองการดูแลสุขภาพของเราและคุณยังสามารถขอให้มีการแปลเอกสารเป็นภาษาที่คุณใช้ได้โดยไม่มีการคิดค่าบริการเพียงโทรหาเราที่หมายเลข 1-800-464-4000 ตลอด** 24 **ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้** TTY **โปรดโทรไปที่ 711**

Chinese: 我們每週7天，每天24小時在所有營業時間內免費爲您提供口譯服務。您可以請口譯員協助回答有關我們健康保險的問題。您也可以免費索取翻譯成您所用語言的資料。我們每週7天，每天24小時均歡迎您打電話**1-800-757-7585** 前來聯絡（節假日休息）。聽障及語障專線 (TTY) 使用者請撥 **711**。

Vietnamese: Chúng tôi cung cấp dịch vụ thông dịch miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần, trong tất cả các giờ làm việc. Quý vị có thể được thông dịch viên giúp trả lời thắc mắc về quyền lợi bảo hiểm sức khỏe của chúng tôi. Quý vị cũng có thể yêu cầu được cấp miễn phí tài liệu phiên dịch ra ngôn ngữ của quý vị. Chỉ cần gọi cho chúng tôi tại số **1-800-464-4000**, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi **711**.

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Services Contact Center 24 hours a day, seven days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may request health plan materials translated in your language, and may also request these materials in large text or in other formats to accommodate your needs. For more information, call **1-800-464-4000** (TTY users call **711**).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. A grievance includes a complaint or an appeal. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage* or *Certificate of Insurance*, or speak with a Member Services representative for the dispute-resolution options that apply to you. This is especially important if you are a Medicare, Medi-Cal, MRMIP, Medi-Cal Access, FEHBP, or CalPERS member because you have different dispute-resolution options available.

You may submit a grievance in the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office located at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By mailing your written grievance to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)
- By completing the grievance form on our website at **kp.org**

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TDD). Complaint forms are available at ***http://www.hhs.gov/ocr/office/file/index.html***.

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, país de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad física o mental, fuente de pago, información genética, ciudadanía, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros (Member Service Contact Center) brinda servicios de asistencia con el idioma las 24 horas del día, los siete días de la semana (excepto los días festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Además, puede solicitar los materiales del plan de salud traducidos a su idioma, y también los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades. Para obtener más información, llame al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Una queja incluye una queja formal o una apelación. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)*, o comuníquese con un representante de Servicio a los Miembros (Member Services) para conocer las opciones de resolución de disputas que le corresponden. Esto tiene especial importancia si es miembro de Medicare, Medi-Cal, MRMIP (Major Risk Medical Insurance Program, Programa de Seguro Médico para Riesgos Mayores), Medi-Cal Access, FEHBP (Federal Employees Health Benefits Program, Programa de Beneficios Médicos para los Empleados Federales) o CalPERS ya que dispone de otras opciones para resolver disputas.

Puede presentar una queja de las siguientes maneras:

- completando un formulario de queja o de reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte las direcciones en *Su Guía*)
- enviando por correo su queja por escrito a una oficina de Servicio a los Miembros en un centro del plan (consulte las direcciones en *Su Guía*)
- llamando a la línea telefónica gratuita de la Central de Llamadas de Servicio a los Miembros al **1-800-788-0616** (los usuarios de la línea TTY deben llamar al **711**)
- completando el formulario de queja en nuestro sitio web en **kp.org**

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al coordinador de derechos civiles (Civil Rights Coordinator) de Kaiser Permanente de todas las quejas relacionadas con la discriminación por motivos de raza, color, país de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U. S. Department of Health and Human Services) mediante el portal de quejas formales de la Oficina de Derechos Civiles, en *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (línea TDD). Los formularios de queja formal están disponibles en ***http://www.hhs.gov/ocr/office/file/index.html***.

Kaiser Permanente禁止以年齡、種族、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達方式、性取向、婚姻狀況、生理或心理殘障、支付來源、遺傳資訊、公民身份、主要語言或移民身份為由而對任何人進行歧視。

計畫成員服務聯絡中心提供語言協助服務；每週七天24小時晝夜服務（法定節假日除外）。本機構在全部辦公時間內免費為您提供口譯服務，其中包括手語。我們還可為您、您的親屬和朋友提供任何必要的特別補助，以便您使用本機構的設施與服務 。此外，您還可請求以您的語言提供健康保險計畫資料之譯本，並可請求採用大號字體或其他版本格式提供此類資料的譯本，藉以滿足您的需求。若需詳細資訊，請致電**1-800-757-7585**（TTY專線使用者請撥**711**）。

冤情申訴係指您或您的授權代表透過冤情申訴程序所表達的不滿陳訴。申訴冤情包括投訴或上訴。例如，如果您認為自己受到本機構的歧視，則可提出冤情申訴。若需瞭解可供您選擇的適用爭議解決方案，請參閱您的《保險計畫承保項目說明書》或《保險證明書》，或者與計畫成員服務代表交談。對於Medicare、Medi-Cal、MRMIP、Medi-Cal Access、FEHBP或CalPERS計畫成員，這尤其重要；原因在於，為這些成員提供的爭議解決方案選擇有所不同。

您可透過以下方式提出冤情申訴：

- 於設在本計畫服務設施的某個計畫成員服務處填妥一份《投訴或保險福利索償/請書》（請參閱您的《通訊地址指南冊》，以便查找相關地址）
- 將您的冤情申訴書郵寄至設在本計畫服務設施的某個計畫成員服務處（請參閱您的《通訊地址指南冊》，以便查找相關地址）
- 致電本機構的計畫成員服務聯絡中心，電話號碼是 **1-800-757-7585**（TTY 專線使用者請撥 **711**）
- 在本機構的網站上填妥一份冤情申訴書，網址是 **kp.org**

如果您在提交冤情申訴書的過程中需要協助，請致電本機構的計畫成員服務聯絡中心。

涉及種族、膚色、原國籍、性別、年齡或身體殘障歧視的一切冤情申訴都將通告給Kaiser Permanente的民權事務協調員。您也可與Kaiser Permanente的民權服務協調員直接聯絡；聯絡地址是One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612。

您還可以採用電子方式透過民權辦公處的投訴入口網站向美國衛生與公共服務部民權辦公處提出民權投訴，網址是*https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*； 或者按照如下聯絡資訊採用郵寄或電話方式聯絡：U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697（TDD 專線)。可從網站上下載投訴書，網址是***http://www.hhs.gov/ocr/office/file/index.html***。

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Delta Dental Combined Evidence of Coverage and Disclosure Form (Pediatric Dental Coverage)

Health Plan Benefits and Coverage Matrix

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

Accumulation Period

The Accumulation Period for this plan is 1/1/17 through 12/31/17 (calendar year).

Out-of-Pocket Maximum(s) and Deductible(s)

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

For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductible(s) apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$6,750	$6,750	$13,500
Plan Deductible	$1,000	$1,000	$2,000
Drug Deductible	$200	$200	$400

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$50 per visit (Plan Deductible doesn't apply)
Most Physician Specialist Visits	$50 per visit (Plan Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Family planning counseling and consultations	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	$50 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	$50 per visit (Plan Deductible doesn't apply)

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	30% Coinsurance after Plan Deductible
Allergy injections (including allergy serum)	$5 per visit (Plan Deductible doesn't apply)
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	$50 per encounter (Plan Deductible doesn't apply)
Preventive X-rays, screenings, and laboratory tests as described in the "Benefits and Your Cost Share" section	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	30% Coinsurance after Plan Deductible
Covered individual health education counseling	No charge (Plan Deductible doesn't apply)
Covered health education programs	No charge (Plan Deductible doesn't apply)

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	30% Coinsurance after Plan Deductible

Emergency Health Coverage	**You Pay**
Emergency Department visits	30% Coinsurance after Plan Deductible

Note: This Cost Share does not apply if you are admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	**You Pay**
Ambulance Services	30% Coinsurance after Plan Deductible

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$25 for up to a 30-day supply (Drug Deductible doesn't apply)
Most generic refills through our mail-order service	$50 for up to a 100-day supply (Drug Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$50 for up to a 30-day supply after Drug Deductible
Most brand-name refills through our mail-order service	$100 for up to a 100-day supply after Drug Deductible
Most specialty items at a Plan Pharmacy	20% Coinsurance (not to exceed $250) for up to a 30-day supply after Drug Deductible
Durable Medical Equipment (DME)	**You Pay**
DME items that are essential health benefits in accord with our DME formulary guidelines	30% Coinsurance (Plan Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	30% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$50 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment	$25 per visit (Plan Deductible doesn't apply)
Chemical Dependency Services	**You Pay**
Inpatient detoxification	30% Coinsurance after Plan Deductible
Individual outpatient chemical dependency evaluation and treatment	$50 per visit (Plan Deductible doesn't apply)
Group outpatient chemical dependency treatment	$5 per visit (Plan Deductible doesn't apply)
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)
Other	**You Pay**
Eyeglasses or contact lenses for Pediatric Members:	
One complete pair of eyeglasses (frames and lenses) or one pair of contact lenses per Accumulation Period, as described in the "Benefits and Your Cost Share" section	No charge (Plan Deductible doesn't apply)
Skilled Nursing Facility care (up to 100 days per benefit period)	30% Coinsurance after Plan Deductible
Prosthetic and orthotic devices	No charge (Plan Deductible doesn't apply)
Hospice care	No charge (Plan Deductible doesn't apply)

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the "Benefits and Your Cost Share" and "Exclusions, Limitations, Coordination of Benefits, and Reductions" sections. Except as described under "Dental and Orthodontic Services" in the "Benefits and Your Cost Share" section below, dental coverage is not described in this *DF/EOC*. For a description of covered dental services you receive by enrolling in this *DF/EOC*, please refer to the Delta Dental Combined Evidence of Coverage and Disclosure Form (Delta Dental DF/EOC) attached to this *DF/EOC*. If you have separately purchased other dental coverage, please refer to the evidence of coverage or certificate of insurance from your dental plan provider for information about that other dental plan coverage.

Introduction

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

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

For benefits provided under any other Health Plan program, refer to that plan's evidence of coverage. For benefits provided under any other program offered by your Group (for example, workers compensation benefits), refer to your Group's materials.

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

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

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

Pediatric Dental Coverage

Except as described under "Dental and Orthodontic Services" in the "Benefits and Your Cost Share" section below, dental services are not covered under this *DF/EOC*. Information in this *DF/EOC*, such as how to get care, descriptions of services that are covered, and how to resolve issues related to your health care coverage, pertains only to Services covered under this *DF/EOC*.

When you enroll in this Kaiser Permanente coverage, you are also automatically enrolling in a separate pediatric dental plan underwritten by Delta Dental of California, which will provide coverage of dental benefits for any children under age 19 that you enroll.

These dental benefits are described in the Delta Dental DF/EOC attached to this *DF/EOC*. Please refer to this Delta Dental DF/EOC for information about your dental coverage, such as how to get care, and services that are covered.

Renewal

Coverage of dental services benefits under the Delta Dental DF/EOC attached to this *DF/EOC* will automatically renew upon the renewal of this *DF/EOC*.

Premiums

Premiums due under this *DF/EOC* include the dental services underwritten by Delta Dental of California described in the attached Delta Dental DF/EOC.

Dispute Resolution

Delta Dental is responsible for administering and resolving enrollee complaints, grievances and appeals that concern dental services covered by the Delta Dental DF/EOC. Please refer to the Delta Dental DF/EOC attached to this *DF/EOC* for information regarding these complaints, grievances and appeals. Health Plan is responsible for administering and resolving any enrollee complaints, grievances and appeals that concern enrollment, premium collection and/or termination relating to this pediatric dental coverage.

Termination

Coverage of dental services benefits under the Delta Dental DF/EOC attached to this *DF/EOC* will automatically terminate upon the termination of this *DF/EOC* (for example, if your coverage under this *DF/EOC* terminates because you lose eligibility as a Dependent, your coverage under the Delta Dental DF/EOC will terminate at the same time). Delta Dental will not separately terminate its dental services coverage under the Delta Dental DF/EOC. If Delta Dental stops offering the pediatric dental plan described in the Delta Dental DF/EOC during the term of this *DF/EOC*, we will make arrangements for the Services to be provided by another pediatric dental plan and notify you of the arrangements.

Term of this *DF/EOC*

This *DF/EOC* is for the period January 1, 2017, through December 31, 2017, unless amended. Your Group can tell you whether this *DF/EOC* is still in effect and give

you a current one if this *DF/EOC* has expired or been amended.

Information about renewal of pediatric dental coverage is described under "Pediatric Dental Coverage" in the "Introduction" section of this *DF/EOC*.

About Kaiser Permanente

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

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits and Your Cost Share" section
- Visiting Member Services as described under "Receiving Care in the Service Area of another Region" in the "How to Obtain Services" section

Definitions

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

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable) and out-of-pocket maximums. For example, the Accumulation Period may be a calendar year or contract year. The Accumulation Period for this *DF/EOC* is from January 1, 2017, through December 31, 2017.

Adult Member: A Member who is age 19 or older and is not a Pediatric Member. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1.

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

Charges: "Charges" means the following:

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

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

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

Cost Share: The amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those

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

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

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

Drug Deductible: The amount you must pay in the Accumulation Period for certain drugs, supplies, and supplements before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Please refer to the "Outpatient Prescription Drugs, Supplies, and Supplements" section to learn whether your coverage includes a Drug Deductible, the Services that are subject to the Drug Deductible, and the Drug Deductible amount.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable person would have believed that the absence of immediate medical attention would result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to himself or herself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

Emergency Services: All of the following with respect to an Emergency Medical Condition:

- A medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post Stabilization Care and not Emergency Services)

***Evidence of Coverage (EOC)* or combined *Disclosure Form and Evidence of Coverage (DF/EOC)*:** This *EOC* or *DF/EOC* document, including any amendments, which describes the health care coverage of "Kaiser Permanente Deductible HMO Plan" under Health Plan's *Agreement* with your Group.

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

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

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

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region).

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

Medical Group: The Southern California Permanente Medical Group, a for-profit professional partnership.

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

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). In this *DF/EOC*, 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 "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 under this *DF/EOC*, and for whom we have received applicable Premiums. This *DF/EOC* sometimes refers to a Member as "you."

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

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.

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

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

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

Pediatric Member: A Member from birth through the end of the month of his or her 19th birthday. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1 and your last minute as a Pediatric Member will be 11:59 p.m. on June 30.

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

Plan Deductible: The amount you must pay in the Accumulation Period for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Please refer to the "Benefits and Your Cost Share" section to learn whether your coverage includes a Plan Deductible, the Services that are subject to the Plan Deductible, and the Plan Deductible amount.

Plan Facility: Any facility listed on our website at **kp.org/facilities** for our Service Area, except that Plan Facilities are subject to change at any time without notice. For the current locations of Plan Facilities, please call our Member Service Contact Center.

Plan Hospital: Any hospital listed on our website at **kp.org/facilities** for our Service Area, except that Plan Hospitals are subject to change at any time without notice. For the current locations of Plan Hospitals, please call our Member Service Contact Center.

Plan Medical Office: Any medical office listed on our website at **kp.org/facilities** for our Service Area, except that Plan Medical Offices are subject to change at any time without notice. For the current locations of Plan Medical Offices, please call our Member Service Contact Center.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Please refer to *Your Guidebook* for a list of Plan Optical Sales Offices in your area, except that Plan Optical Sales Offices are subject to change at any time without notice. For the current locations of Plan Optical Sales Offices, please call our Member Service Contact Center.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay under this *DF/EOC* in the Accumulation Period for certain covered Services that you receive in the same Accumulation Period. Please refer to the "Benefits and Your Cost Share" section to find your Plan Out-of-Pocket Maximum amount and to learn which Services apply to the Plan Out-of-Pocket Maximum.

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

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

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

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

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that this condition is Stabilized.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *DF/EOC*, except that you are responsible for paying Premiums if you have Cal-COBRA coverage.

Preventive Services: Covered Services that prevent or detect illness and do one or more of the following:

- Protect against disease and disability or further progression of a disease

- Detect disease in its earliest stages before noticeable symptoms develop

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Please refer to our website at **kp.org** for a directory of Primary Care Physicians, except that the directory is subject to change without notice. For the current list of physicians that are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook*.

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

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

Service Area: The ZIP codes below for each county are in our Service Area:

- The following ZIP codes in Imperial County are inside our Service Area: 92274–75
- The following ZIP codes in Kern County are inside our Service Area: 93203, 93205–06, 93215–16, 93220, 93222, 93224–26, 93238, 93240–41, 93243, 93249–52, 93263, 93268, 93276, 93280, 93285, 93287, 93301–09, 93311–14, 93380, 93383–90, 93501–02, 93504–05, 93518–19, 93531, 93536, 93560–61, 93581
- The following ZIP codes in Los Angeles County are inside our Service Area: 90001–84, 90086–91, 90093–96, 90099, 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, 90301–12, 90401–11, 90501–10, 90601–10, 90623, 90630–31, 90637–40, 90650–52, 90660–62, 90670–71, 90701–03, 90706–07, 90710–17, 90723, 90731–34, 90744–49, 90755, 90801–10, 90813–15, 90822, 90831–35, 90840, 90842, 90844, 90846–48, 90853, 90895, 90899, 91001, 91003, 91006–12, 91016–17, 91020–21, 91023–25, 91030–31, 91040–43, 91046, 91066, 91077, 91101–10, 91114–18, 91121, 91123–26, 91129, 91182, 91184–85, 91188–89, 91199, 91201–10, 91214, 91221–22, 91224–26, 91301–11, 91313, 91316, 91321–22, 91324–31, 91333–35, 91337, 91340–46, 91350–57, 91361–62, 91364–65, 91367, 91371–72, 91376, 91380–87, 91390, 91392–96, 91401–13, 91416, 91423, 91426, 91436, 91470, 91482, 91495–96, 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, 91801–04, 91896, 91899, 93243, 93510, 93532, 93534–36, 93539, 93543–44, 93550–53, 93560, 93563, 93584, 93586, 93590–91, 93599
- All ZIP codes in Orange County are inside our Service Area: 90620–24, 90630–33, 90638, 90680, 90720–21, 90740, 90742–43, 92602–07, 92609–10, 92612, 92614–20, 92623–30, 92637, 92646–63, 92672–79, 92683–85, 92688, 92690–94, 92697–98, 92701–08, 92711–12, 92728, 92735, 92780–82, 92799, 92801–09, 92811–12, 92814–17, 92821–23, 92825, 92831–38, 92840–46, 92850, 92856–57, 92859, 92861–71, 92885–87, 92899
- The following ZIP codes in Riverside County are inside our Service Area: 91752, 92028, 92201–03, 92210–11, 92220, 92223, 92230, 92234–36, 92240–41, 92247–48, 92253–55, 92258, 92260–64, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501–09, 92513–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92589–93, 92595–96, 92599, 92860, 92877–83
- The following ZIP codes in San Bernardino County are inside our Service Area: 91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758–59, 91761–64, 91766, 91784–86, 91792, 92252, 92256, 92268, 92277–78, 92284–86, 92305, 92307–08, 92313–18, 92321–22, 92324–25, 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, 92410–11, 92413, 92415, 92418, 92423, 92427, 92880
- The following ZIP codes in San Diego County are inside our Service Area: 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–46, 91950–51, 91962–63, 91976–80, 91987, 92003, 92007–11, 92013–14, 92018–30, 92033, 92037–40, 92046, 92049, 92051–52, 92054–61, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92081–86, 92088, 92091–93, 92096, 92101–24, 92126–32, 92134–40, 92142–43, 92145, 92147, 92149–50, 92152–55, 92158–61, 92163, 92165–79, 92182, 92186–87, 92190–93, 92195–99
- The following ZIP codes in Tulare County are inside our Service Area: 93238, 93261
- The following ZIP codes in Ventura County are inside our Service Area: 90265, 91304, 91307, 91311,

91319–20, 91358–62, 91377, 93001–07, 93009–12, 93015–16, 93020–22, 93030–36, 93040–44, 93060–66, 93094, 93099, 93252

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

If you have a question about whether a ZIP code is in our Service Area, please call our Member Service Contact Center.

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

Services: Health care services or items ("health care" includes both physical health care and mental health care) and behavioral health treatment covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Benefits and Your Cost Share" section.

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

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

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

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

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

Premiums, Eligibility, and Enrollment

Premiums

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

Who Is Eligible

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

Group eligibility requirements

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

Service Area eligibility requirements

The "Definitions" section describes our Service Area and how it may change.

Subscribers must live or work inside our Service Area at the time they enroll. If after enrollment the Subscriber no longer lives or works inside our Service Area, the Subscriber can continue membership unless (1) he or she lives inside or moves to the service area of another Region and does not work inside our Service Area, or (2)

your Group does not allow continued enrollment of Subscribers who do not live or work inside our Service Area.

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

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

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

For more information about the service areas of the other Regions, please call our Member Service Contact Center.

Eligibility as a Subscriber

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

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

Newborn coverage

If you are already enrolled under this *DF/EOC* and have a baby, your newborn will automatically be covered for 31 days from the date of birth. If you do not enroll the newborn within 60 days, he or she is covered for only 31 days (including the date of birth).

Eligibility as a Dependent

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

- Your Spouse
- Your or your Spouse's Dependent children, who are under age 26, if they are any of the following:
  - sons, daughters, or stepchildren
  - adopted children
  - children placed with you for adoption
  - children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)
- Children whose parent is a Dependent under your family coverage (including adopted children and children placed with your Dependent for adoption) if they meet all of the following requirements:
  - they are not married and do not have a domestic partner (for the purposes of this requirement only, "domestic partner" means someone who is registered and legally recognized as a domestic partner by California)
  - they are under age 26
  - they receive all of their support and maintenance from you or your Spouse
  - they permanently reside with you or your Spouse
- Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption) who reach the age limit may continue coverage under this *DF/EOC* if all of the following conditions are met:
  - they meet all requirements to be a Dependent except for the age limit
  - your Group permits enrollment of Dependents
  - they are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
  - they receive 50 percent or more of their support and maintenance from you or your Spouse
  - you give us proof of their incapacity and dependency within 60 days after we request it (see "Disabled Dependent certification" below in this "Eligibility as a Dependent" section)
- Children placed with the Subscriber or Spouse for foster care who enroll during a special enrollment

period triggered by the placement of that child in foster care

Disabled Dependent certification. One of the requirements for a Dependent to be eligible to continue coverage as a disabled Dependent is that the Subscriber must provide us documentation of the dependent's incapacity and dependency as follows:

- If the child is a Member, we will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent's incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as a disabled dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that the Dependent does not meet the eligibility requirements as a disabled dependent, we will notify the Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If we determine that the Dependent is eligible as a disabled dependent, there will be no lapse in coverage. Also, starting two years after the date that the Dependent reached the age limit, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as a disabled dependent
- If the child is not a Member because you are changing coverages, you must give us proof, within 60 days after we request it, of the child's incapacity and dependency as well as proof of the child's coverage under your prior coverage. In the future, you must provide proof of the child's continued incapacity and dependency within 60 days after your receive our request, but not more frequently than annually

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

Persons barred from enrolling

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

Members with Medicare and retirees

This *DF/EOC* is not intended for retirees and most Medicare beneficiaries. If, during the term of this *DF/EOC*, you are (or become) eligible for Medicare (please see "Medicare" in the "Definitions" section for the meaning of "eligible for" Medicare) or you retire, the following will apply:

- If you are the Subscriber and you retire, membership under this *DF/EOC* will be terminated and you may be eligible to continue membership as described in the "Continuation of Membership" section
- If federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary, your coverage under this *DF/EOC* will be the same as it would be if you had not become eligible for Medicare. However, you may also be eligible to enroll in Kaiser Permanente Senior Advantage through your Group if you have Medicare Part B
- If none of the above applies to you and you are eligible for Medicare please ask your Group about your membership options

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

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

Medicare late enrollment penalties

If you become eligible for Medicare Part B and do not enroll, Medicare may require you to pay a late enrollment penalty if you later enroll in Medicare Part B.

However, if you delay enrollment in Part B because you or your spouse are still working and have coverage through an employer group health plan, you may not have to pay the penalty. Also, if you are (or become) eligible for Medicare and go without creditable prescription drug coverage (drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage) for a continuous period of 63 days or more, you may have to pay a late enrollment penalty if you later sign up for Medicare prescription drug coverage. If you are (or become) eligible for Medicare, your Group is responsible for informing you about whether your drug coverage under this *DF/EOC* is creditable prescription drug coverage at the times required by the Centers for Medicare & Medicaid Services and upon your request.

When You Can Enroll and When Coverage Begins

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

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

New employees

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

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

Open enrollment

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

Special enrollment

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

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

Special enrollment due to new Dependents. You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 60 days after marriage, establishment of domestic partnership, birth, adoption, placement for adoption, or placement for foster care by submitting to your Group a Health Plan–approved enrollment application.

The effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber. Enrollments due to birth, adoption, placement for adoption, or placement for foster care are effective on the date of birth, date of adoption, or the date you or your Spouse have newly assumed a legal right to control health care.

Special enrollment due to loss of other coverage. You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, if all of the following are true:

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

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

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 60 days after loss of other coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Special enrollment due to court or administrative order. Within 60 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application.

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

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

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

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

- You lose minimum essential coverage (for a reason other than nonpayment of Premiums, termination for cause, or rescission of coverage):
  - you lose your group health plan coverage (for example, you lose eligibility as a subscriber because you lose your job or your hours are reduced, you lose eligibility as a dependent due to legal separation, divorce, or reaching the age limit for dependent children, or you exhaust COBRA or Cal-COBRA coverage)
  - you lose eligibility for individual plan coverage, Medicare, Medi-Cal, or other government-sponsored health care program coverage
- You become eligible for membership as a result of a permanent move
- You were recently released from incarceration
- You are an American Indian or Native Alaskan and Covered California determines that you are eligible for a monthly special enrollment period
- Covered California determines that you are entitled to a special enrollment period (for example, Covered

California determines that you didn't apply for coverage during the prior open enrollment because you were misinformed that you had minimum essential coverage)

- You were under active care for certain conditions with a provider whose participation in your health plan ended (examples of conditions include: an acute condition, a serious chronic condition, pregnancy, terminal illness, care of newborn, or authorized nonelective surgeries)

To request special enrollment, you must submit an application within 30 days after loss of other coverage. You may be required to provide documentation that you have experienced a qualifying event. If you are requesting enrollment in a plan offered through Covered California, submit your application to Covered California. If you are not requesting enrollment in a plan offered through Covered California, you must submit a Health Plan-approved enrollment application to your Group. Membership becomes effective either on the first day of the next month (for applications that are received by the fifteenth day of a month) or on the first day of the month following the next month (for applications that are received after the fifteenth day of a month).

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

How to Obtain Services

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

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits and Your Cost Share" section
- Visiting Member Services as described under "Receiving Care in the Service Area of another Region" in this "How to Obtain Services" section

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

Routine Care

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

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

To make a non-urgent appointment, please refer to *Your Guidebook* for appointment telephone numbers, or go to our website at **kp.org** to request an appointment online.

Urgent Care

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice telephone number at a Plan Facility. Please refer to *Your Guidebook* or the facility directory on our website at **kp.org** for appointment and advice telephone numbers.

For information about Out-of-Area Urgent Care, please refer to "Urgent Care" in the "Emergency Services and Urgent Care" section.

Not Sure What Kind of Care You Need?

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

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

You can reach one of these licensed health care professionals by calling the appointment or advice telephone number listed in *Your Guidebook* or the facility directory on our website at **kp.org**. When you call, a trained support person may ask you questions to help determine how to direct your call.

Your Personal Plan Physician

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

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

To learn how to select or change to a different personal Plan Physician, please refer to *Your Guidebook*, visit our website at **kp.org**, or call our Member Service Contact Center. You can find a directory of our Plan Physicians on our website at **kp.org**. For the current list of physicians that are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook*. You can change your personal Plan Physician at any time for any reason.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, urology, dermatology, and physical, occupational, and speech therapies. Also, a Plan Physician must refer you before you can get care from Qualified Autism Service Providers covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Benefits and Your Cost Share" section. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, psychiatry, chemical dependency, and obstetrics/gynecology

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

- The provider may have to get prior authorization for certain Services in accord with "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

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

Medical Group authorization procedure for certain referrals

The following are examples of Services that 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):

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management (UM) is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. For the complete list of Services that require prior authorization, and the criteria that are

used to make authorization decisions, please visit our website at **kp.org/UM** or call our Member Service Contact Center. Please refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

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

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

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

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

Your Cost Share. Your Cost Share for these referral Services is the Cost Share required for Services provided by a Plan Provider as described in this *DF/EOC*.

Travel and lodging for certain referrals

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

- If Medical Group refers you to a provider that is more than 50 miles from where you live for certain specialty Services such as bariatric surgery, thoracic surgery, transplant nephrectomy, or inpatient chemotherapy for leukemia and lymphoma
- If Medical Group refers you to a provider that is outside our Service Area for certain specialty Services such as a transplant or transgender surgery

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

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
- Serious chronic conditions until the earlier of (1) 12 months from your effective date of coverage if you are a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the

first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:

- it persists without full cure
- it worsens over an extended period of time
- it requires ongoing treatment to maintain remission or prevent deterioration

- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the child's effective date of coverage if the child is a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your effective date of coverage if you are a new Member or within 180 days of the termination date of the terminated provider

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

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

Your Cost Share. Your Cost Share for completion of Services is the Cost Share required for Services provided by a Plan Provider as described in this *DF/EOC*.

More information. For more information about this provision, or to request the Services or a copy of our "Completion of Covered Services" policy, please call our Member Service Contact Center.

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an appropriately qualified medical professional for your condition. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with a Non–Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion.

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

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

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

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

Your Cost Share. Your Cost Share for these referral Services is the Cost Share required for Services provided by a Plan Provider as described in this *DF/EOC*.

Interactive Video Visits

Interactive video visits between you and your provider are intended to make it more convenient for you to receive covered Services, when a Plan Provider determines it is medically appropriate for your medical condition. You may receive covered Services via interactive video visits, when available and if the Services would have been covered under this *DF/EOC* if provided in person. You are not required to use interactive video visits. If you do agree to use interactive video visits, you may be charged Cost Share for the Services you receive. (For example, if you have an interactive video visit consultation with a specialist, you may be charged the Cost Share for a Physician Specialist Visit.)

Contracts with Plan Providers

How Plan Providers are paid

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

Financial liability

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

Termination of a Plan Provider's contract

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

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

Receiving Care in the Service Area of another Region

If you are visiting in the service area of another Region, you may receive Visiting Member Services from designated providers in that Region. "Visiting Member Services" are Services that are covered under your Home Region plan that you receive in another Region, subject to exclusions, limitations, and reductions described in this *DF/EOC* or the Visiting Member Brochure, which is available online at **kp.org**. For more information about receiving Visiting Member Services in another Region, including limits on the availability of Visiting Member Services, prior authorization or approval requirements, and provider and facility locations, or to obtain a copy of the Visiting Member Brochure, please call our Away from Home Travel Line at **951-268-3900** 24 hours a day, seven days a week (except closed holidays). Information is also available online at **kp.org/travel**.

Your Cost Share. Your Cost Share for Visiting Member Services is **the Cost Share required for Services provided by a Plan Provider inside our Service Area** as described in this *DF/EOC*.

Your ID Card

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

Member Service Contact Center if we ever inadvertently issue you more than one medical record number or if you need to replace your Kaiser Permanente ID card.

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

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

Member Services

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

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

You can reach Member Services in the following ways:

Call	**1-800-464-4000** (English) **1-800-788-0616** (Spanish) **1-800-757-7585** (Chinese dialects) TTY users call **711** 24 hours a day, seven days a week (except closed holidays)
Visit	Member Services Department at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for addresses)
Write	Member Services Department at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for addresses)
Website	**kp.org**

Cost Share estimates

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

Away from home travel line

If you have questions about your coverage when you are away from home, call **951-268-3900** 24 hours a day, seven days a week (except closed holidays). For example, call this number for the following concerns:

- What you should do to prepare for your trip
- What Services are covered when you are outside our Service Area
- How to get care in another Region
- How to request reimbursement if you paid for covered Services outside our Service Area

You can also get information on our website at **kp.org/travel**.

Interpreter services

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

Plan Facilities

Plan Medical Offices and Plan Hospitals for your area are listed in *Your Guidebook to Kaiser Permanente Services (Your Guidebook)* and on our website at **kp.org**. *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. Also, it explains how to use our Services and make appointments, lists hours of operation, and includes a detailed telephone directory for appointments and advice. If you have any questions about the current locations of Plan Medical Offices and/or Plan Hospitals, please call our Member Service Contact Center.

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

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week

- Emergency Services are available from Plan Hospital Emergency Departments as described in *Your Guidebook* (please refer to *Your Guidebook* or the facility directory on our website at **kp.org** for Emergency Department locations in your area)
- Same–day Urgent Care appointments are available at many locations (please refer to *Your Guidebook* or the facility directory on our website at **kp.org** 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* or the facility directory on our website at **kp.org** for locations in your area)

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

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

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

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital Emergency Department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world.

Emergency Services are available from Plan Hospital Emergency Departments 24 hours a day, seven days a week.

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that this condition is Stabilized. We cover Post-Stabilization Care from a Non–Plan Provider only if we provide prior authorization for the care or if otherwise required by applicable law ("prior authorization" means that we must approve the Services in advance).

To request prior authorization, the provider must call **1-800-225-8883** or the notification telephone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non–Plan Provider. If we determine that you require Post-Stabilization Care and that this care is part of your covered benefits, we will authorize your care from the Non–Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non–Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

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

Your Cost Share

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

- If you receive Emergency Services in the Emergency Department of a Non–Plan Hospital, you pay the Cost Share for an Emergency Department visit as described under "Outpatient Care"

- If we gave prior authorization for inpatient Post-Stabilization Care in a Non–Plan Hospital, you pay the Cost Share for hospital inpatient care as described under "Hospital Inpatient Care"

Urgent Care

Inside the Service Area

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

Out-of-Area Urgent Care

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

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

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

We do not cover follow-up care from Non–Plan Providers after you no longer need Urgent Care. To obtain follow-up care from a Plan Provider, call the appointment or advice telephone number listed in *Your Guidebook*.

Your Cost Share

Your Cost Share for covered Urgent Care is the Cost Share required for Services provided by Plan Providers as described in this *DF/EOC*. For example:

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non–Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described under "Outpatient Care"
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described under "Outpatient Imaging, Laboratory, and Special Procedures" in addition to the Cost Share for the Urgent Care evaluation

Note: If you receive Urgent Care in an Emergency Department, you pay the Cost Share for an Emergency Department visit as described under "Outpatient Care."

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits and Your Cost Share" section, you are not responsible for any amounts beyond your Cost Share for covered Emergency Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. Also, you may be required to pay and file a claim for any Services prescribed by a Non–Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy.

For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Benefits and Your Cost Share

We cover the Services described in this "Benefits and Your Cost Share" section, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section, only if all of the following conditions are satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - Preventive Services
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits and Your Cost Share" section
  - other health care items and services

- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the sections listed below for the following Services:
  - drugs prescribed by dentists as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section
  - emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Your Cost Share" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
  - eyeglasses and contact lenses prescribed by Non–Plan Providers as described under "Vision Services for Adult Members" and "Vision Services for Pediatric Members" in this "Benefits and Your Cost Share" section
  - Visiting Member Services as described under "Receiving Care in the Service Area of another Region" in the "How to Obtain Services" section
- You receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary in the sections listed below for the following Services:
  - authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
  - emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Your Cost Share" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
  - hospice care as described under "Hospice Care" in this "Benefits and Your Cost Share" section
  - Visiting Member Services as described under "Receiving Care in the Service Area of another Region" in the "How to Obtain Services" section
- The Medical Group has given prior authorization for the Services if required under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

The only Services we cover under this *DF/EOC* are those that this *DF/EOC* says that we cover, subject to exclusions and limitations described in this *DF/EOC* and to all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. The "Exclusions, Limitations, Coordination of Benefits, and Reductions" section describes exclusions, limitations, reductions, and coordination of benefits provisions that apply to all Services that would otherwise be covered. When an exclusion or limitation applies only to a particular benefit, it is listed in the description of that benefit in this *DF/EOC*. Also, please refer to:

- The "Emergency Services and Urgent Care" section for information about how to obtain covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care
- *Your Guidebook* for the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services

Your Cost Share

Your Cost Share is the amount you are required to pay for covered Services. The Cost Share for covered Services is listed in this *DF/EOC*. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

General rules, examples, and exceptions

Your Cost Share for covered Services will be the Cost Share in effect on the date you receive the Services, except as follows:

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

Cost Share for Services received by newborn children of a Member. During the 31 days of automatic coverage for newborn children described under "Newborn coverage" under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, the parent or guardian of the newborn must pay the Cost Share indicated in this "Benefits and Your Cost Share" section for any Services that the newborn receives, whether or not the newborn is enrolled. When the Cost Share for the Services is described as "subject to the Plan Deductible," the Cost Share for those Services will be Charges if the newborn has not met the Plan Deductible.

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

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

In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for your Cost Share. The following are examples of when you will be billed:

- A Plan Provider is not able to collect Cost Share at the time you receive Services (for example, some Laboratory Departments are not able to collect Cost Shares)
- You ask to be billed for some or all of your Cost Share
- Medical Group authorizes a referral to a Non–Plan Provider and that provider does not collect your Cost Share at the time you receive Services
- You receive covered Emergency Services or Out-of-Area Urgent Care from a Non–Plan Provider and that provider does not collect your Cost Share at the time you receive Services

When we send you a bill, it will list Charges for the Services you received, payments and credits applied to your account, and any amounts you still owe. Your current bill may not always reflect your most recent Charges and payments. Any Charges and payments that are not on the current bill will appear on a future bill. Sometimes, you may see a payment but not the related Charges for Services. That could be because your payment was recorded before the Charges for the Services were processed. If so, the Charges will appear on a future bill. Also, you may receive more than one bill for a single outpatient visit or inpatient stay. For example, you may receive a bill for physician services and a separate bill for hospital services. If you don't see all the Charges for Services on one bill, they will appear on a future bill. If we determine that you overpaid and are due a refund, then we will send a refund to you within 4 weeks after we make that determination. If you have questions about a bill, please call the phone number on the bill.

Primary Care Visits, Non-Physician Specialist Visits, and Physician Specialist Visits. The Cost Share for a Primary Care Visit applies to evaluations and treatment provided by generalists in internal medicine, pediatrics,

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

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

Getting an estimate of your Cost Share

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

- If you are enrolled in the POS Plan and have questions about the Cost Share for specific Services, please call **1-800-788-0710** (TTY users call **711**)
- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call **1-800-390-3507** (TTY users call **711**) Monday through Friday 7 a.m. to 5 p.m.
- For all other Cost Share estimates, please call **1-800-464-4000** (TTY users call **711**)

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

Member statements

After you receive Services that are subject to the Plan Deductible and Plan Out-of-Pocket Maximum, we will also send you a summary or explanation of benefits. It shows your total accumulation toward the Plan Deductible and Plan Out-of-Pocket Maximum. The summary or explanation of benefits may not always reflect your most recent Charges and payments. Any Charges and payments that are not on the current summary will appear on a future summary. You can also obtain a copy of this summary or explanation of benefits by calling our Member Service Contact Center at **1-800-390-3507** (TTY users call **711**) Monday through Friday 7 a.m. to 5 p.m.

Drug Deductible

Please refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section for Services that are subject to the Drug Deductible and the Drug Deductible amount. When the Cost Share for the Services is described as "subject to the Drug Deductible," your Cost Share for those Services will be Charges until you reach the Drug Deductible. Note: When the Cost Share for the Services is described as "no charge subject to the Drug Deductible," your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Plan Deductible

In any Accumulation Period, you must pay Charges for Services subject to the Plan Deductible until you reach one of the following Plan Deductible amounts:

Self-only coverage (a Family of one Member):

- **$1,000** per Accumulation Period

Family coverage (a Family of two or more Members):

- **$1,000** per Accumulation Period for each Member in the Family
- **$2,000** per Accumulation Period for the entire Family

If you are a Member in a Family of two or more Members, you reach the Plan Deductible either when you reach the amount for any one Member, or when your entire Family reaches the Family amount. For example, suppose you have reached the **$1,000** amount for any one Member. For Services subject to the Plan Deductible, you will not pay Charges during the remainder of the Accumulation Period, but every other Member in your Family must continue to pay Charges during the remainder of the Accumulation Period until either he or she reaches the **$1,000** amount for any one Member, or the entire Family reaches the **$2,000** Family amount.

After you reach the Plan Deductible and for the remainder of the Accumulation Period, you pay the applicable Copayment or Coinsurance subject to the limits described under "Plan Out-of-Pocket Maximum" in this "Benefits and Your Cost Share" section.

Services that are subject to the Plan Deductible. The Cost Share that you must pay for covered Services is described in this *DF/EOC*. When the Cost Share for the Services is described as "subject to the Plan Deductible," your Cost Share for those Services will be Charges until you reach the Plan Deductible. Note: When the Cost Share for the Services is described as "no charge subject to the Plan Deductible," your Cost Share for those Services will be Charges until you reach the Plan Deductible. Also, if you pay a Plan Deductible amount for a Service that has a limit, such as a visit limit, the Services count toward reaching the limit.

The only payments that count toward the Plan Deductible are those you make for covered Services that are subject to this Plan Deductible under this *DF/EOC*.

Keeping track of the Plan Deductible. When you pay an amount toward your Plan Deductible, we will give you a receipt that shows how much you paid. To see how close you are to reaching your Plan Deductible, use our online Out-of-Pocket Summary tool at **kp.org/outofpocket**, refer to your summary or explanation of benefits, or call our Member Service Contact Center.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service, after you meet any applicable deductible, is described in this *DF/EOC*.

Note: If Charges for Services are less than the Copayment described in this *DF/EOC*, you will pay the lesser amount.

Plan Out-of-Pocket Maximum

There is a limit to the total amount of Cost Share you must pay under this *DF/EOC* in the Accumulation Period for covered Services that you receive in the same Accumulation Period. The Services that apply to the Plan Out-of-Pocket Maximum are described under the "Payments that count toward the Plan Out-of-Pocket Maximum" section below. The limit is one of the following amounts:

Self-only coverage (a Family of one Member):

- **$6,750** per Accumulation Period

Family coverage (a Family of two or more Members):

- **$6,750** per Accumulation Period for each Member in the Family
- **$13,500** per Accumulation Period for the entire Family

If you are a Member in a Family of two or more Members, you reach the Plan Out-of-Pocket Maximum either when you reach the maximum for any one Member, or when your Family reaches the Family maximum. For example, suppose you have reached the **$6,750** maximum for any one Member. For Services subject to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share during the remainder of the Accumulation Period, but every other Member in your Family must continue to pay Cost Share during the remainder of the Accumulation Period until either he or she reaches the **$6,750** maximum for any one Member or your Family reaches the **$13,500** Family maximum.

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

Also, Copayments and Coinsurance you pay for covered Services apply to the maximum, except as described below:

- If your plan includes supplemental chiropractic or acupuncture Services described in an Amendment to this *DF/EOC*, those Services do not apply toward the maximum
- If your plan includes an Allowance for specific Services (such as eyeglasses, contact lenses, or hearing aids), any amounts you pay that exceed the Allowance do not apply toward the maximum

If your plan includes pediatric dental Services described in a Pediatric Dental Services Amendment to this *DF/EOC*, those Services will apply toward the maximum.

Keeping track of the Plan Out-of-Pocket Maximum. When you receive Services, we will give you a receipt that shows how much you paid. To see how close you are to reaching your Plan Out-of-Pocket Maximum, use our online Out-of-Pocket Summary tool at **kp.org/outofpocket** or call our Member Service Contact Center.

Outpatient Care

We cover the following outpatient care subject to the Cost Share indicated:

Outpatient visits

- Primary Care Visits and Non-Physician Specialist Visits, other than those described below in this "Outpatient Care" section: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- Physician Specialist Visits other than those described below in this "Outpatient Care" section: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- Outpatient visits that are available as group appointments: **a $25 Copayment per visit (not subject to the Plan Deductible)**
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge (not subject to the Plan Deductible)**
- Acupuncture Services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain):
  - Non-Physician Specialist Visits: **a $50 Copayment per visit (not subject to the Plan Deductible)**
  - Physician Specialist Visits: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- Allergy testing and treatment
  - consultations for allergy conditions and allergy testing: **a $50 Copayment per visit (not subject to the Plan Deductible)**
  - allergy injections (including allergy serum): **a $5 Copayment per visit (not subject to the Plan Deductible)**

Emergency and Urgent Care visits

- Emergency Department visits: **30% Coinsurance subject to the Plan Deductible**. If you are admitted to the hospital as an inpatient for covered Services (either directly or after an observation stay), then the Services you received in the Emergency Department and observation stay, if applicable, will be considered part of your inpatient hospital stay. For the Cost Share for inpatient care, please refer to "Hospital Inpatient Care" in this "Benefits and Your Cost Share" section. However, the Emergency Department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient
- Urgent Care consultations, evaluations, and treatment: **a $50 Copayment per visit (not subject to the Plan Deductible)**

Outpatient surgeries and procedures

- Outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **30% Coinsurance subject to the Plan Deductible**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $50 Copayment per procedure (not subject to the Plan Deductible)**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Special Procedures")

Administered drugs and products

Administered drugs and products are medications and products that require administration or observation by medical personnel. We cover these items when prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility or during home visits.

Certain administered drugs are Preventive Services. Please refer to "Family Planning Services" for information about administered contraceptives and refer to "Preventive Services" for information on immunizations.

We cover the following Services and their administration in a Plan Facility at the Cost Share indicated:

- Blood and blood products: **no charge (not subject to the Plan Deductible)**
- Cancer chemotherapy drugs and adjuncts: **no charge (not subject to the Plan Deductible)**
- Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy: **no charge (not subject to the Plan Deductible)**
- All other administered drugs: **no charge (not subject to the Plan Deductible)**

We cover drugs and products administered to you during a home visit at **no charge (not subject to the Plan Deductible).**

Coverage for Services related to "Outpatient Care" described in other sections

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

- Bariatric Surgery
- Behavioral Health Treatment for Pervasive Developmental Disorder or Autism
- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Durable Medical Equipment for Home Use
- Family Planning Services
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Ostomy and Urological Supplies
- Outpatient Imaging, Laboratory, and Special Procedures
- Outpatient Prescription Drugs, Supplies, and Supplements
- Preventive Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Rehabilitative and Habilitative Services
- Services in Connection with a Clinical Trial
- Transplant Services
- Vision Services for Adult Members
- Vision Services for Pediatric Members

Hospital Inpatient Care

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

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, please refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and special procedures, including MRI, CT, and PET scans
- Blood, blood products, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, please refer to "Outpatient Care" in this "Benefits and Your Cost Share" section)
- Behavioral health treatment for pervasive developmental disorder or autism
- Respiratory therapy
- Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation program)
- Medical social services and discharge planning

Your Cost Share. We cover hospital inpatient Services at **30% Coinsurance subject to the Plan Deductible**.

Coverage for Services related to "Hospital Inpatient Care" described in other sections

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

- Bariatric Surgery
- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Hospice Care
- Infertility Services

- Mental Health Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services in Connection with a Clinical Trial
- Skilled Nursing Facility Care
- Transplant Services

Ambulance Services

Emergency

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

- A reasonable person would have believed that the medical condition was an Emergency Medical Condition which required ambulance Services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

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

Nonemergency

Inside our Service Area, we cover nonemergency ambulance and psychiatric transport van Services if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services.

Your Cost Share

You pay the following for covered ambulance Services:

- Emergency ambulance Services: **30% Coinsurance subject to the Plan Deductible**
- Nonemergency Services: **30% Coinsurance subject to the Plan Deductible**

Ambulance Services exclusion(s)

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

Bariatric Surgery

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

- You complete the Medical Group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success
- A Plan Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary

Your Cost Share. For covered Services related to bariatric surgical procedures that you receive, you will pay the **Cost Share you would pay if the Services were not related to a bariatric surgical procedure**. For example, see "Hospital Inpatient Care" in this "Benefits and Your Cost Share" section for the Cost Share that applies for hospital inpatient care.

Coverage for Services related to "Bariatric Surgery" described in other sections

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Behavioral Health Treatment for Pervasive Developmental Disorder or Autism

The following terms have special meaning when capitalized and used in this "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" section:

- "Qualified Autism Service Provider" means a provider who has the experience and competence to design, supervise, provide, or administer treatment for pervasive developmental disorder or autism and is either of the following:
  - a person, entity, or group that is certified by a national entity (such as the Behavior Analyst Certification Board) that is accredited by the National Commission for Certifying Agencies
  - a person licensed in California as a physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist
- "Qualified Autism Service Professional" means a person who meets all of the following criteria:
  - provides behavioral health treatment
  - is employed and supervised by a Qualified Autism Service Provider
  - provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
  - is a behavioral health treatment provider approved as a vendor by a California regional center to provide Services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section 54342 of Title 17 of the California Code of Regulations
  - has training and experience in providing Services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code
- "Qualified Autism Service Paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:
  - is employed and supervised by a Qualified Autism Service Provider
  - provides treatment and implements Services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
  - meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code
  - has adequate education, training, and experience, as certified by a Qualified Autism Service Provider

We cover behavioral health treatment for pervasive developmental disorder or autism (including applied behavior analysis and evidence-based behavior intervention programs) that develops or restores, to the maximum extent practicable, the functioning of a person with pervasive developmental disorder or autism and that meet all of the following criteria:

- The Services are provided inside our Service Area
- The treatment is prescribed by a Plan Physician, or is developed by a Plan Provider who is a psychologist
- The treatment is provided under a treatment plan prescribed by a Plan Provider who is a Qualified Autism Service Provider
- The treatment is administered by a Plan Provider who is one of the following:
  - a Qualified Autism Service Provider
  - a Qualified Autism Service Professional supervised and employed by the Qualified Autism Service Provider
  - a Qualified Autism Service Paraprofessional supervised and employed by a Qualified Autism Service Provider
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the Member being treated
- The treatment plan is reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate
- The treatment plan requires the Qualified Autism Service Provider to do all of the following:
  - describe the Member's behavioral health impairments to be treated
  - design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported
  - provide intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism

- ♦ discontinue intensive behavioral intervention Services when the treatment goals and objectives are achieved or no longer appropriate
- The treatment plan is not used for either of the following:
  - ♦ for purposes of providing (or for the reimbursement of) respite care, day care, or educational services
  - ♦ to reimburse a parent for participating in the treatment program

Your Cost Share. You pay the following for these covered Services:

- Individual visits: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- Group visits: **a $25 Copayment per visit (not subject to the Plan Deductible)**

Chemical Dependency Services

Outpatient chemical dependency care

We cover the following Services for treatment of chemical dependency:

- Day-treatment programs
- Individual and group chemical dependency counseling
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms

Your Cost Share. You pay the following for these covered Services:

- Individual chemical dependency evaluation and treatment: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- Group chemical dependency treatment: **a $5 Copayment per visit (not subject to the Plan Deductible)**
- Intensive outpatient and day-treatment programs: **30% Coinsurance up to a maximum of $5 per day (not subject to the Plan Deductible)**

Residential treatment

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

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

Your Cost Share. We cover residential chemical dependency treatment Services at **30% Coinsurance subject to the Plan Deductible**.

Inpatient detoxification

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

Your Cost Share. We cover inpatient detoxification Services at **30% Coinsurance subject to the Plan Deductible**.

Coverage for Services related to "Chemical Dependency Services" described in other sections

- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Dental and Orthodontic Services

We do not cover most dental and orthodontic Services, but we do cover some dental and orthodontic Services as described in this "Dental and Orthodontic Services" section.

Dental Services for radiation treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a Plan

Physician provides the Services or if the Medical Group authorizes a referral to a dentist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

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

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

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

Accidental injury to teeth

Services for accidental injury to teeth are not covered.

Dental and orthodontic Services for cleft palate

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

- The Services are an integral part of a reconstructive surgery for cleft palate that we are covering under "Reconstructive Surgery" in this "Benefits and Your Cost Share" section ("cleft palate" includes cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate)
- A Plan Provider provides the Services or the Medical Group authorizes a referral to a Non–Plan Provider who is a dentist or orthodontist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)

Your Cost Share

You pay the following for dental and orthodontic Services covered under this "Dental and Orthodontic Services" section:

- Primary Care Visits and Non-Physician Specialist Visits (including visits with dentists and orthodontists for Services covered under this "Dental and Orthodontic Services" section): **a $50 Copayment per visit (not subject to the Plan Deductible)**
- Physician Specialist Visits: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- Outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **30% Coinsurance subject to the Plan Deductible**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $50 Copayment per procedure (not subject to the Plan Deductible)**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Special Procedures")
- Hospital inpatient care (including room and board, drugs, imaging, laboratory, special procedures, and Plan Physician Services): **30% Coinsurance subject to the Plan Deductible**

Coverage for Services related to "Dental and Orthodontic Services" described in other sections

- Outpatient imaging, laboratory, and special procedures (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient administered drugs (refer to "Outpatient Care"), except that we cover outpatient administered drugs under "Dental anesthesia" in this "Dental and Orthodontic Services" section
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Dialysis Care

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

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

After you receive appropriate training at a dialysis facility we designate, we also cover equipment and

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

Your Cost Share. You pay the following for these covered Services related to dialysis:

- Equipment and supplies for home hemodialysis and home peritoneal dialysis: **no charge (not subject to the Plan Deductible)**
- One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment: **no charge (not subject to the Plan Deductible)**
- Hemodialysis treatment at a Plan Facility: **no charge (not subject to the Plan Deductible)**
- All other Primary Care Visits and Non-Physician Specialist Visits: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- All other Physician Specialist Visits: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- Hospital inpatient care (including room and board, drugs, imaging, laboratory, and special procedures, and Plan Physician Services): **30% Coinsurance subject to the Plan Deductible**

Coverage for Services related to "Dialysis Care" described in other sections

- Durable medical equipment for home use (refer to "Durable Medical Equipment for Home Use")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Dialysis Care exclusion(s)

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

Durable Medical Equipment for Home Use

Inside our Service Area, we cover the durable medical equipment specified in this "Durable Medical Equipment for Home Use" section for use in your home (or another location used as your home) in accord with our durable medical equipment formulary guidelines. Durable medical equipment for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

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

Durable medical equipment items that are essential health benefits

Inside our Service Area, we cover the following durable medical equipment (including repair or replacement of covered equipment) at **30% Coinsurance (not subject to the Plan Deductible)**:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Bone stimulator
- Canes (standard curved handle or quad) and replacement supplies
- Cervical traction (over door)
- Crutches (standard or forearm) and replacement supplies
- Dry pressure pad for a mattress
- Enteral pump and supplies
- Infusion pumps (such as insulin pumps) and supplies to operate the pump
- IV pole
- Nebulizer and supplies
- Peak flow meters
- Phototherapy blankets for treatment of jaundice in newborns
- Tracheostomy tube and supplies

Breastfeeding supplies

We cover at **no charge (not subject to the Plan Deductible)** one retail-grade breast pump per pregnancy

and the necessary supplies to operate it, such as one set of bottles. We will decide whether to rent or purchase the item and we choose the vendor. We cover this pump for convenience purposes. The pump is not subject to prior authorization requirements or the formulary guidelines.

Inside our Service Area, if you or your baby has a medical condition that requires the use of a breast pump, we cover at **no charge (not subject to the Plan Deductible)** a hospital-grade breast pump and the necessary supplies to operate it, in accord with our durable medical equipment formulary guidelines. We will determine whether to rent or purchase the equipment and we choose the vendor. Hospital-grade breast pumps on our formulary are subject to the durable medical equipment prior authorization requirements as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section. For more information about our durable medical equipment formulary, see the "About our durable medical equipment formulary" in this "Durable Medical Equipment for Home Use" section.

Durable medical equipment items that are not essential health benefits

Durable medical equipment that are not essential health benefits are not covered.

Outside our Service Area

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

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

About our durable medical equipment formulary

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

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

Coverage for Services related to "Durable Medical Equipment for Home Use" described in other sections

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Insulin and any other drugs administered with an infusion pump (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Durable medical equipment for home use exclusion(s)

- Comfort, convenience, or luxury equipment or features except for retail-grade breast pumps as described under "Breastfeeding supplies" in this "Durable Medical Equipment for Home Use" section
- Repair or replacement of equipment due to loss or misuse

Family Planning Services

We cover the following family planning Services subject to the Cost Share indicated:

- Family planning counseling: **no charge (not subject to the Plan Deductible)**
- Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices (IUDs) and office visits related to their administration and management: **no charge (not subject to the Plan Deductible)**
- Female sterilization procedures if provided in an outpatient or ambulatory surgery center or in a hospital operating room: **no charge (not subject to the Plan Deductible)**
- All other female sterilization procedures: **no charge (not subject to the Plan Deductible)**
- Male sterilization procedures if provided in an outpatient or ambulatory surgery center or in a hospital operating room: **30% Coinsurance subject to the Plan Deductible**
- All other male sterilization procedures: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- Termination of pregnancy: **30% Coinsurance subject to the Plan Deductible**

Coverage for Services related to "Family Planning Services" described in other sections

- Services to diagnose or treat infertility (refer to "Infertility Services")
- Outpatient administered drugs that are not contraceptives (refer to "Outpatient Care")
- Outpatient laboratory and imaging services associated with family planning services (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient contraceptive drugs and devices (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Family Planning Services exclusion(s)

- Reversal of voluntary sterilization

Health Education

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

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

For more information about our health education counseling, programs, and materials, please contact a Health Education Department or our Member Service Contact Center, refer to *Your Guidebook*, or go to our website at **kp.org**.

Your Cost Share. You pay the following for these covered Services:

- Covered health education programs, which may include programs provided online and counseling over the phone: **no charge (not subject to the Plan Deductible)**
- Individual counseling during an office visit related to smoking cessation: **no charge (not subject to the Plan Deductible)**
- Individual counseling during an office visit related to diabetes management: **no charge (not subject to the Plan Deductible)**
- Other covered individual counseling when the office visit is solely for health education: **no charge (not subject to the Plan Deductible)**
- Health education provided during an outpatient consultation or evaluation covered in another part of this *DF/EOC*: **no additional Cost Share beyond the Cost Share required in that other part of this *DF/EOC***
- Covered health education materials: **no charge (not subject to the Plan Deductible)**

Hearing Services

We cover the following:

- Hearing exams with an audiologist to determine the need for hearing correction: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- Physician Specialist Visits to diagnose and treat hearing problems: **a $50 Copayment per visit (not subject to the Plan Deductible)**

Hearing aids

Hearing aids and related Services are not covered. For internally implanted devices, see "Prosthetic and

Orthotic Devices" in this "Benefits and Your Cost Share" section.

Coverage for Services related to "Hearing Services" described in other sections

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

Hearing Services exclusion(s)

- Hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover home health care only if all of the following are true:

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

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

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

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

Your Cost Share. We cover home health care Services at **no charge (not subject to the Plan Deductible)**.

Coverage for Services related to "Home Health Care" described in other sections

- Behavioral health treatment for pervasive developmental disorder or autism (refer to "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism")
- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Home health care exclusion(s)

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

Hospice Care

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

We cover the hospice Services listed below at **no charge (not subject to the Plan Deductible)** only if all of the following requirements are met:

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

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

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

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

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

Infertility Services

For purposes of this "Infertility Services" section, "infertility" means not being able to get pregnant or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or having a medical or other demonstrated condition that is recognized by a Plan Physician as a cause of infertility.

Diagnosis and treatment of infertility and artificial insemination Services

Services for the diagnosis and treatment of infertility or artificial insemination are not covered.

Assisted reproductive technology (ART) Services

Assisted reproductive technology Services such as invitro fertilization (IVF), gamete intra-fallopian transfer (GIFT), or zygote intrafallopian transfer (ZIFT) are not covered.

Coverage for Services related to "Infertility Services" described in other sections

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Infertility Services exclusion(s)

- Services to diagnose or treat infertility
- Services to reverse voluntary, surgically induced infertility

- Semen and eggs (and Services related to their procurement and storage)
- Conception by artificial means, such as ovum transplants, GIFT, semen and eggs (and Services related to their procurement and storage), IVF, and ZIFT

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, as amended in the most recently issued edition, *(DSM)* that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the *DSM* identifies as something other than a "mental disorder." For example, the *DSM* identifies relational problems as something other than a "mental disorder," so we do not cover services (such as couples counseling or family counseling) for relational problems.

"Mental Disorders" include the following conditions:

- Severe Mental Illness of a person of any age. "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa
- A Serious Emotional Disturbance of a child under age 18. A "Serious Emotional Disturbance" of a child under age 18 means a condition identified as a "mental disorder" in the *DSM*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:
  - as a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
  - the child displays psychotic features, or risk of suicide or violence due to a mental disorder
  - the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

Outpatient mental health Services

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

- Individual and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

Intensive psychiatric treatment programs. We cover the following intensive psychiatric treatment programs at a Plan Facility:

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

Your Cost Share. You pay the following for these covered Services:

- Individual mental health evaluation and treatment: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- Group mental health treatment: **a $25 Copayment per visit (not subject to the Plan Deductible)**
- Partial hospitalization: **30% Coinsurance up to a maximum of $50 per day subject to the Plan Deductible**
- Other intensive psychiatric treatment programs: **30% Coinsurance up to a maximum of $50 per day subject to the Plan Deductible**

Residential treatment

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

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

Your Cost Share. We cover residential mental health treatment Services at **30% Coinsurance subject to the Plan Deductible**.

Inpatient psychiatric hospitalization

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

Your Cost Share. We cover inpatient psychiatric hospital Services at **30% Coinsurance subject to the Plan Deductible**.

Coverage for Services related to "Mental Health Services" described in other sections

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

Ostomy and Urological Supplies

We cover ostomy and urological supplies prescribed in accord with our soft goods formulary guidelines. We select the vendor, and coverage is limited to the standard supply that adequately meets your medical needs. We cover these Services at **no charge (not subject to the Plan Deductible)**.

About our soft goods formulary

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

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

Ostomy and urological supplies exclusion(s)

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Special Procedures

We cover the following Services at the Cost Share indicated only when prescribed as part of care covered under other headings in this "Benefits and Your Cost Share" section:

- Certain outpatient imaging and laboratory Services are Preventive Services. You can find more information about the Preventive Services we cover under "Preventive Services" in this "Benefits and Your Cost Share" section
- All other CT scans, and all MRIs and PET scans: **30% Coinsurance subject to the Plan Deductible**

- All other imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds:
  - if the imaging Services are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **30% Coinsurance subject to the Plan Deductible**
  - if the imaging Services do not require a licensed staff member to monitor your vital signs as described above: **a $50 Copayment per encounter (not subject to the Plan Deductible)**
- Nuclear medicine: **a $50 Copayment per encounter (not subject to the Plan Deductible)**
- Routine retinal photography screenings: **no charge (not subject to the Plan Deductible)**
- Routine laboratory tests to monitor the effectiveness of dialysis: **no charge (not subject to the Plan Deductible)**
- All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available): **a $50 Copayment per encounter (not subject to the Plan Deductible)**
- All other diagnostic procedures provided by Plan Providers who are not physicians (such as EKGs and EEGs):
  - if the diagnostic procedures are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **30% Coinsurance subject to the Plan Deductible**
  - if the diagnostic procedures do not require a licensed staff member to monitor your vital signs as described above: **a $50 Copayment per encounter (not subject to the Plan Deductible)**
- Radiation therapy: **no charge (not subject to the Plan Deductible)**
- Ultraviolet light treatments: **no charge (not subject to the Plan Deductible)**

Coverage for Services related to "Outpatient Imaging, Laboratory, and Special Procedures" described in other sections

- Services related to diagnosis and treatment of infertility (refer to "Infertility Services")

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section when prescribed as follows and obtained at a Plan Pharmacy or through our mail-order service:

- Items prescribed by Plan Providers, within the scope of their licensure and practice, and in accord with our drug formulary guidelines
- Items prescribed by the following Non–Plan Providers unless a Plan Physician determines that the item is not Medically Necessary or the drug is for a sexual dysfunction disorder:
  - Dentists if the drug is for dental care
  - Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) and the drug, supply, or supplement is covered as part of that referral
  - Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described under "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)

How to obtain covered items

You must obtain covered items at a Plan Pharmacy or through our mail-order service unless you obtain the item as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section.

Please refer to *Your Guidebook* or the facility directory on our website at **kp.org** for the locations of Plan Pharmacies in your area.

Refills. You may be able to order refills at a Plan Pharmacy, through our mail-order service, or through our website at **kp.org/rxrefill**. A Plan Pharmacy or *Your Guidebook* can give you more information about obtaining refills, including the options available to you for obtaining refills. For example, a few Plan Pharmacies don't dispense refills and not all drugs can be mailed through our mail-order service. Please check with a Plan Pharmacy if you have a question about whether your

prescription can be mailed or obtained at a Plan Pharmacy. Items available through our mail-order service are subject to change at any time without notice.

Day supply limit

The prescribing physician or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians determine the amount of an item that constitutes a Medically Necessary 30- or 100-day supply for you. Upon payment of the Cost Share specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, you will receive the supply prescribed up to the day supply limit also specified in this section. The day supply limit is either one 30-day supply in a 30-day period or one 100-day supply in a 100-day period. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit. Note: We cover episodic drugs prescribed for the treatment of sexual dysfunction disorders up to a maximum of 8 doses in any 30-day period or up to 27 doses in any 100-day period.

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

About the drug formulary

The drug formulary includes a list of drugs that our Pharmacy and Therapeutics Committee has approved for our Members. 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 at least quarterly to consider additions and deletions based on new information or drugs that become available. To find out which drugs are on the formulary for your plan, please visit our website at **kp.org/formulary**. If you would like to request a copy of the drug formulary for your plan, please call our Member Service Contact Center. Note: The presence of a drug on the drug formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition.

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 "Dispute Resolution" section. Also, our formulary guidelines may require you to participate in a behavioral intervention program approved by the Medical Group for specific conditions and you may be required to pay for the program.

About specialty drugs

Specialty drugs are high-cost drugs that are on our specialty drug list. To obtain a list of specialty drugs that are on our formulary, or to find out if a nonformulary drug is on the specialty drug list, please call our Member Service Contact Center. If your Plan Physician prescribes more than a 30-day supply for an outpatient drug, you may be able to obtain more than a 30-day supply at one time, up to the day supply limit for that drug. However, most specialty drugs are limited to a 30-day supply in any 30-day period. Your Plan Pharmacy can tell you if a drug you take is one of these drugs.

General rules about coverage and your Cost Share

We cover the following outpatient drugs, supplies, and supplements as described in this "Outpatient Prescription Drugs, Supplies, and Supplements" section:

- Drugs for which a prescription is required by law. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs

Note:

- If Charges for the drug, supply, or supplement are less than the Copayment, you will pay the lesser amount
- Items can change tier at any time, in accord with formulary guidelines, which may impact your Cost Share (for example, if a brand-name drug is added to the specialty drug list, you will pay the Cost Share that applies to drugs on the specialty drug tier, not the Cost Share for drugs on the brand-name drug tier)

Continuity drugs. If this *DF/EOC* is amended to exclude a drug that we have been covering and providing to you under this *DF/EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same

condition and for a use approved by the federal Food and Drug Administration:

- Generic continuity drugs: **50% Coinsurance (not to exceed $50) for up to a 100-day supply (not subject to the Drug Deductible)**
- Brand-name continuity drugs: **50% Coinsurance (not to exceed $100) for up to a 100-day supply subject to the Drug Deductible**

Mail order service. Prescription refills can be mailed within 7 to 10 days at no extra cost for standard U.S. postage. The appropriate Cost Share (according to your drug coverage) will apply and must be charged to a valid credit card.

You may request mail order service in the following ways:

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

Note: Not all drugs can be mailed; restrictions and limitations apply.

Drug Deductible. In any Accumulation Period, you must pay Charges for any items covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section that are subject to the Drug Deductible until you meet one of the following Drug Deductible amounts:

Self-only coverage (a Family of one Member):

- **$200** per Accumulation Period

Family coverage (a Family of two or more Members):

- **$200** per Accumulation Period for each Member in the Family
- **$400** per Accumulation Period for the entire Family

The only payments that count toward this Drug Deductible are those you make under this *DF/EOC* for covered items that are subject to this Drug Deductible. After you reach the Drug Deductible, you pay the applicable Copayments or Coinsurance for these items for the remainder of the Accumulation Period.

Services that are subject to the Drug Deductible. The Cost Share that you must pay for covered Services is described in this *DF/EOC*. When the Cost Share for the Services is described as "subject to the Drug Deductible," your Cost Share for those Services will be Charges if until you reach the Drug Deductible. Note: When the Cost Share for the Services is described as "no charge subject to the Drug Deductible," your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Coverage and your Cost Share for most items

Drugs, supplies, and supplements are covered as follows except for items listed under "Other items:"

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

Item	Your Cost Share at a Plan Pharmacy	Your Cost Share By Mail
Items on the generic tier **(not subject to the Drug Deductible)**	$25 for up to a 30-day supply	$50 for up to a 100-day supply
Items on the brand-name tier **subject to the Drug Deductible**	$50 for up to a 30-day supply	$100 for up to a 100-day supply
Items on the specialty tier **subject to the Drug Deductible**	20% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy

Other items

Coverage and your Cost Share listed above for most items does not apply to the items list under "Other items." Coverage and your Cost Share for these other items is as follows:

Base drugs, supplies, and supplements

We cover the following items at the Cost Share indicated:

- Certain drugs for the treatment of life-threatening ventricular arrhythmia
- Drugs for the treatment of tuberculosis

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

Item	Your Cost Share at a Plan Pharmacy	Your Cost Share By Mail
Hematopoietic agents for dialysis **(not subject to the Drug Deductible)**	No charge for up to a 30-day supply	Not available
Elemental dietary enteral formula when used as a primary therapy for regional enteritis **(not subject to the Drug Deductible)**	20% Coinsurance for up to a 30-day supply	Not available
All other items on the generic tier **(not subject to the Drug Deductible)**	$25 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy
All other items on the brand-name tier **(not subject to the Drug Deductible)**	$50 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy
All other items on the specialty tier **subject to the Drug Deductible**	20% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy

Anticancer drugs and certain critical adjuncts following a diagnosis of cancer

Item	Your Cost Share at a Plan Pharmacy	Your Cost Share By Mail
Oral anticancer drugs on the generic tier **(not subject to the Drug Deductible)**	$25 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy
Oral anticancer drugs on the brand-name tier **(not subject to the Drug Deductible)**	$50 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy
Oral anticancer drugs on the specialty tier **(not subject to the Drug Deductible)**	20% Coinsurance (not to exceed $200) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy
Non-oral anticancer drugs on the generic tier **(not subject to the Drug Deductible)**	$25 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy
Non-oral anticancer drugs on the brand-name tier **(not subject to the Drug Deductible)**	$50 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy
Non-oral anticancer drugs on the specialty tier **subject to the Drug Deductible**	20% Coinsurance (not to exceed $250) for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy

Home infusion drugs

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

Item	Your Cost Share at a Plan Pharmacy	Your Cost Share By Mail
Home infusion drugs **(not subject to the Drug Deductible)**	No charge for up to a 30-day supply	Not available
Supplies necessary for administration of home infusion drugs **(not subject to the Drug Deductible)**	No charge	No charge

Diabetes supplies and amino acid–modified products

Item	Your Cost Share at a Plan Pharmacy	Your Cost Share By Mail
Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) **(not subject to the Drug Deductible)**	No charge for up to a 30-day supply	Not available
Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing **(not subject to the Drug Deductible)**	No charge for up to a 100-day supply	Not available
Insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear) **(not subject to the Drug Deductible)**	$25 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy

Note: Drugs related to the treatment of diabetes (for example, insulin) are not covered under this "Diabetes supplies and amino-acid modified products" section.

Contraceptive drugs and devices

Item	Your Cost Share at a Plan Pharmacy	Your Cost Share By Mail
The following contraceptive items for women on the generic tier when prescribed by a Plan Provider **(not subject to the Drug Deductible)**: • Rings • Patches • Female condoms • Oral contraceptives • Spermicide • Sponges	No charge for up to a 100-day supply	No charge for up to a 100-day supply Rings and items that do not require a prescription by law are not available for mail order
The following contraceptive items on the brand-name tier for women when prescribed by a Plan Provider **(not subject to the Drug Deductible)**: • Rings • Patches • Female condoms • Oral contraceptives • Spermicide • Sponges	No charge for up to a 100-day supply	No charge for up to a 100-day supply Rings and items that do not require a prescription by law are not available for mail order
Emergency contraception **(not subject to the Drug Deductible)**	No charge	Not available
Diaphragms and cervical caps **(not subject to the Drug Deductible)**	No charge	Not available

Certain preventive items

Item	Your Cost Share at a Plan Pharmacy	Your Cost Share By Mail
Items on our Preventive Services under Health Reform list on our website at **kp.org/prevention** when prescribed by a Plan Provider **(not subject to the Drug Deductible)**	No charge for up to a 100-day supply	Not available

Infertility and sexual dysfunction drugs

Item	Your Cost Share at a Plan Pharmacy	Your Cost Share By Mail
Drugs on the generic tier prescribed to treat infertility	Not covered	Not covered
Drugs on the brand-name and specialty tiers prescribed to treat infertility	Not covered	Not covered
Drugs on the generic tier prescribed in connection with covered assisted reproductive technology (ART) Services	Not covered	Not covered
Drugs on the brand-name and specialty tiers prescribed in connection with covered assisted reproductive technology (ART) Services	Not covered	Not covered
Drugs on the generic tier prescribed for sexual dysfunction disorders **(not subject to the Drug Deductible)**	$25 for up to a 30-day supply	$50 for up to a 100-day supply
Drugs on the brand-name and specialty tiers prescribed for sexual dysfunction disorders **subject to the Drug Deductible**	$50 for up to a 30-day supply	$100 for up to a 100-day supply

Coverage for Services related to "Outpatient Prescription Drugs, Supplies, and Supplements" described in other sections

- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment for Home Use")
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care")
- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment for Home Use")
- Outpatient administered drugs (refer to "Outpatient Care")

Outpatient prescription drugs, supplies, and supplements exclusion(s)

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the drug is listed on our drug formulary or one of the ingredients requires a prescription by law
- Drugs prescribed to shorten the duration of the common cold
- All drugs, supplies, and supplements for diagnosis and treatment of infertility
- All drugs, supplies, and supplements related to assisted reproductive technology (ART) Services

Preventive Services

We cover a variety of Preventive Services, including but not limited to the following:

- Services recommended by the United States Preventive Services Task Force with rating of "A" or "B." The complete list of these services can be found at **uspreventiveservicestaskforce.org**
- Immunizations listed on the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians

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

The list of Preventive Services recommended by the above organizations is subject to change. These Preventive Services are subject to all coverage requirements described in this "Benefits and Your Cost Share" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. You may obtain a list of Preventive Services we cover on our website at **kp.org/prevention**. If you have questions about Preventive Services, please call our Member Service Contact Center.

Note: If you receive any other covered Services that are not Preventive Services during or subsequent to a visit that includes Preventive Services on the list, you will pay the applicable Cost Share for those other Services.

Your Cost Share. You pay the following for covered Preventive Services:

- Preventive Services received during an office visit:
  - routine physical exams, including well-woman exams: **no charge (not subject to the Plan Deductible)**
  - well child preventive exams for Members through age 23 months: **no charge (not subject to the Plan Deductible)**
  - after confirmation of pregnancy, the normal series of regularly scheduled preventive prenatal care exams: **no charge (not subject to the Plan Deductible)**
  - the first postpartum follow-up consultation and exam: **no charge (not subject to the Plan Deductible)**
  - immunizations (including the vaccine) administered to you in a Plan Medical Office: **no charge (not subject to the Plan Deductible)**
  - tuberculosis skin tests: **no charge (not subject to the Plan Deductible)**
  - screening and counseling Services when provided during a routine physical exam or a well-child preventive exam, such as obesity counseling, routine vision screenings, alcohol and substance abuse screenings, health education, depression screening, and developmental screenings to diagnose and assess potential developmental delays: **no charge (not subject to the Plan Deductible)**
  - routine hearing screenings: **no charge (not subject to the Plan Deductible)**
- Outpatient procedures that are Preventive Services:
  - sterilization procedures for women: refer to "Family Planning Services" in this "Benefits and Your Cost Share" section for coverage and Cost Share information
  - screening colonoscopies: **no charge (not subject to the Plan Deductible)**
  - screening flexible sigmoidoscopies: **no charge (not subject to the Plan Deductible)**
- Outpatient imaging and laboratory Services that are Preventive Services
  - routine imaging screenings such as mammograms: **no charge (not subject to the Plan Deductible)**
  - bone density CT scans: **no charge (not subject to the Plan Deductible)**
  - bone density DEXA scans: **no charge (not subject to the Plan Deductible)**
  - routine laboratory tests and screenings such as cancer screening tests, sexually transmitted infection (STI) tests, cholesterol screening tests, and glucose tolerance tests: **no charge (not subject to the Plan Deductible)**
  - other laboratory screening tests, such as fecal occult blood tests and hepatitis B screening tests: **no charge (not subject to the Plan Deductible)**
- Outpatient prescription drugs, supplies and supplements that are Preventive Services:
  - implanted contraceptive drugs and devices for women: refer to "Family Planning Services" in this "Benefits and Your Cost Share" section for coverage and Cost Share for provider-administered contraceptive drugs and implanted contraceptive devices
  - other contraceptive drugs and devices for women: refer to "Outpatient drugs, supplies, and supplements" in this "Benefits and Your Cost Share" section for coverage and Cost Share information for all other contraceptive drugs and devices
- Other Preventive Services:
  - breast pumps and breastfeeding supplies: refer to Breastfeeding supplies" under "Durable Medical Equipment for Home Use" in this "Benefits and Your Cost Share" section for coverage and Cost Share information

Coverage related to "Preventive Services" described in other sections

- Breast pumps and breastfeeding supplies (refer to "Breastfeeding supplies" under "Durable Medical Equipment for Home Use")
- Health education programs (refer to "Health Education")
- Outpatient drugs, supplies, and supplements that are Preventive Services (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Women's family planning counseling, consultations, and sterilization Services (refer to "Family Planning Services")

Prosthetic and Orthotic Devices

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

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select

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

Prosthetic and orthotic devices that are essential health benefits

Internally implanted devices. We cover prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that we are covering under another section of this "Benefits and Your Cost Share" section. We cover these devices at **no charge subject to the Plan Deductible**.

External devices. We cover the following external prosthetic and orthotic devices at **no charge (not subject to the Plan Deductible)**:

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

Prosthetic and orthotic devices that are not essential health benefits

We cover the following external prosthetic and orthotic devices at **no charge (not subject to the Plan Deductible)**:

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

Coverage for Services related to "Prosthetic and Orthotic Devices" described in other sections

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

Prosthetic and orthotic devices exclusion(s)

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section
- Comfort, convenience, or luxury equipment or features
- Repair or replacement of device due to loss or misuse

- Shoes, shoe inserts, arch supports, or any other footwear, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications and foot disfigurement
- Prosthetic and orthotic devices not intended for maintaining normal activities of daily living (including devices intended to provide additional support for recreational or sports activities)

Reconstructive Surgery

We cover the following reconstructive surgery Services:

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

Your Cost Share. You pay the following for covered reconstructive surgery Services:

- Primary Care Visits and Non-Physician Specialist Visits: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- Physician Specialist Visits: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- Outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **30% Coinsurance subject to the Plan Deductible**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $50 Copayment per procedure (not subject to the Plan Deductible)**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Special Procedures")
- Hospital inpatient care (including room and board, drugs, imaging, laboratory, special procedures, and Plan Physician Services): **30% Coinsurance subject to the Plan Deductible**

Coverage for Services related to "Reconstructive Surgery" described in other sections

- Dental and orthodontic Services that are an integral part of reconstructive surgery for cleft palate (refer to "Dental and Orthodontic Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")

Reconstructive surgery exclusion(s)

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

Rehabilitative and Habilitative Services

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

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

We cover the following Services at the Cost Share indicated:

- Individual outpatient physical, occupational, and speech therapy related to pervasive developmental disorder or autism: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- Group outpatient physical, occupational, and speech therapy related to pervasive developmental disorder

or autism: **a $25 Copayment per visit (not subject to the Plan Deductible)**

- All other individual outpatient physical, occupational, and speech therapy: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- All other group outpatient physical, occupational, and speech therapy: **a $25 Copayment per visit (not subject to the Plan Deductible)**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program: **a $50 Copayment per day (not subject to the Plan Deductible)**

Coverage for Services related to "Rehabilitative and Habilitative Services" described in other sections

- Behavioral health treatment for pervasive developmental disorder or autism (refer to "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism")
- Home health care (refer to "Home Health Care")
- Durable medical equipment (refer to "Durable Medical Equipment for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")
- Physical, occupational, and speech therapy provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care")

Rehabilitative and Habilitative Services exclusion(s)

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

Services in Connection with a Clinical Trial

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

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

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition, and that meets one of the following requirements:

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having an investigational new drug application
- The study or investigation is approved or funded by at least one of the following:
  - the National Institutes of Health
  - the Centers for Disease Control and Prevention
  - the Agency for Health Care Research and Quality
  - the Centers for Medicare & Medicaid Services
  - a cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
  - the Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review

Your Cost Share. For covered Services related to a clinical trial, you will pay the **Cost Share you would**

pay if the Services were not related to a clinical trial. For example, see "Hospital Inpatient Care" in this "Benefits and Your Cost Share" section for the Cost Share that applies for hospital inpatient care.

Services in connection with a clinical trial exclusion(s)

- The investigational Service
- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management

Skilled Nursing Facility Care

Inside our Service Area, we cover up to 100 days per benefit period (including any days we covered under any other Health Plan evidence of coverage offered by your Group) of skilled inpatient Services in a Plan Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

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

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our durable medical equipment formulary if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Blood, blood products, and their administration
- Medical supplies
- Behavioral health treatment for pervasive developmental disorder or autism
- Physical, occupational, and speech therapy
- Respiratory therapy

Your Cost Share. We cover skilled nursing facility Services at **30% Coinsurance subject to the Plan Deductible**.

Coverage for Services related to "Skilled Nursing Facility Care" described in other sections

- Outpatient imaging, laboratory, and special procedures (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient physical, occupational, and speech therapy (refer to "Rehabilitative and Habilitative Services")

Transplant Services

We cover transplants of organs, tissue, or bone marrow if the Medical Group provides a written referral for care to a transplant facility as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

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

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

Your Cost Share. For covered transplant Services that you receive, you will pay the **Cost Share you would pay if the Services were not related to a transplant**. For example, see "Hospital Inpatient Care" in this "Benefits and Your Cost Share" section for the Cost Share that applies for hospital inpatient care.

We provide or pay for donation-related Services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor Services at **no charge (not subject to the Plan Deductible)**.

Coverage for Services related to "Transplant Services" described in other sections

- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Vision Services for Adult Members

We cover the following for Adult Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses: **no charge (not subject to the Plan Deductible)**
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a $50 Copayment per visit (not subject to the Plan Deductible)**

Optical Services

We cover the Services described in this "Optical Services" section at Plan Medical Offices or Plan Optical Sales Offices.

We do not cover eyeglasses or contact lenses (except for special contact lenses described in this "Vision Services for Adult Members" section).

Special contact lenses:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist at **no charge (not subject to the Plan Deductible)**
- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period at **no charge (not subject to the Plan Deductible)** when prescribed by a Plan Physician or Plan Optometrist

Low vision devices

Low vision devices (including fitting and dispensing) are not covered.

Coverage for Services related to "Vision Services for Adult Members" described in other sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Adult Members" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Your Cost Share" section)

Vision Services for Adult Members exclusion(s)

- Contact lenses, including fitting and dispensing, except as described under this "Vision Services for Adult Members" section
- Eyeglass lenses and frames
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Industrial frames
- Low vision devices

Vision Services for Pediatric Members

We cover the following for Pediatric Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses: **no charge (not subject to the Plan Deductible)**
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a $50 Copayment per visit (not subject to the Plan Deductible)**
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a $50 Copayment per visit (not subject to the Plan Deductible)**

Optical Services

We cover the Services described in this "Optical Services" section at Plan Medical Offices or Plan Optical Sales Offices.

Special contact lenses:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month

period when prescribed by a Plan Physician or Plan Optometrist at **no charge (not subject to the Plan Deductible)**

- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period at **no charge (not subject to the Plan Deductible)** when prescribed by a Plan Physician or Plan Optometrist
- If a Plan Physician or Plan Optometrist prescribes contact lenses (other than contact lenses for aniridia and aphakia) that will provide a significant improvement in your vision that eyeglass lenses cannot provide, we cover either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (including fitting and dispensing) in any 12-month period at **no charge (not subject to the Plan Deductible)**

Eyeglasses and contact lenses. If you prefer to wear eyeglasses rather than contact lenses, we cover one complete pair of eyeglasses (frame and Regular Eyeglass Lenses) from our designated value frame collection at **no charge (not subject to the Plan Deductible)** every 12 months when prescribed by a physician or optometrist and a Plan Provider puts the lenses into an eyeglass frame. We cover a clear balance lens when only one eye needs correction. We cover tinted lenses when Medically Necessary to treat macular degeneration or retinitis pigmentosa.

"Regular Eyeglass Lenses" are lenses that meet all of the following requirements:

- They are clear glass, plastic, or polycarbonate lenses
- At least one of the two lenses has refractive value
- They are single vision, flat top multifocal, or lenticular

Eyeglass warranty: Eyeglasses purchased at a Plan Optical Sales Office may include a replacement warranty for up to one year from the original date of dispensing. Please ask your Plan Optical Sales Office for warranty information.

Other contact lenses. If you prefer to wear contact lenses rather than eyeglasses, we cover the following (including fitting and dispensing) at **no charge (not subject to the Plan Deductible)** when prescribed by a physician or optometrist and obtained at a Plan Medical Office or Plan Optical Sales Office:

- Standard contact lenses: one pair of lenses in any 12-month period; or
- Disposable contact lenses: one 6 month supply for each eye in any 12-month period

Low vision devices

If a low-vision device will provide a significant improvement in your vision not obtainable with eyeglasses or contact lenses (or with a combination of eyeglasses and contact lenses), we cover one device (including fitting and dispensing) per Accumulation Period at **no charge (not subject to the Plan Deductible)**.

Coverage for Services related to "Vision Services for Pediatric Members" described in other sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Pediatric Members" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Your Cost Share" section)

Vision Services for Pediatric Members exclusion(s)

- Antireflective coating
- Except for Regular Eyeglass Lenses described in this "Vision Services for Pediatric Members" section, all other lenses such as progressive and High-Index lenses
- Eyeglass or contact lens adornment, such as engraving, faceting, or jeweling
- Industrial frames
- Items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits
- Lenses and sunglasses without refractive value, except as described in this "Vision Services for Pediatric Members" section
- Photochromic or polarized lenses
- Replacement of broken or damaged contact lenses, eyeglass lenses, and frames, except as described in warranty information provided to you at the time of purchase
- Replacement of broken or damaged low vision devices
- Replacement of lost or stolen eyewear

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *DF/EOC* regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in this *DF/EOC*.

Certain exams and Services

Physical exams and other Services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation. This exclusion does not apply if a Plan Physician determines that the Services are Medically Necessary.

Chiropractic Services

Chiropractic Services and the Services of a chiropractor, unless you have coverage for supplemental chiropractic Services as described in an amendment to this *DF/EOC*.

Cosmetic Services

Services that are intended primarily to change or maintain your appearance (including Cosmetic Surgery, which is defined as surgery that is performed to alter or reshape normal structures of the body in order to improve appearance), except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "Benefits and Your Cost Share" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Benefits and Your Cost Share" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after a mastectomy, and prostheses to replace all or part of an external facial body part

Custodial care

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, Skilled Nursing Facility, or inpatient hospital care.

Dental and orthodontic Services

Dental and orthodontic Services such as X-rays, appliances, implants, Services provided by dentists or orthodontists, dental Services following accidental injury to teeth, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment.

This exclusion does not apply to Services covered under "Dental and Orthodontic Services" in the "Benefits and Your Cost Share" section or to pediatric dental Services described in a Pediatric Dental Services Amendment to this *DF/EOC*.

Disposable supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies.

This exclusion does not apply to disposable supplies covered under "Durable Medical Equipment for Home Use," "Home Health Care," "Hospice Care," "Ostomy and Urological Supplies," and "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section.

Experimental or investigational Services

A Service is experimental or investigational if we, in consultation with the Medical Group, determine that one of the following is true:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients)
- It requires government approval that has not been obtained when the Service is to be provided

This exclusion does not apply to any of the following:

- Experimental or investigational Services when an investigational application has been filed with the federal Food and Drug Administration (FDA) and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under "Services in Connection with a Clinical Trial" in the "Benefits and Your Cost Share" section

Please refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Hair loss or growth treatment

Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment for Home Use," "Home Health Care," and "Hospice Care" in the "Benefits and Your Cost Share" section.

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services for the purpose of increasing academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming, except that this exclusion for "teaching play" does not apply to Services that are part of a behavioral health therapy treatment plan and covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Benefits and Your Cost Share" section
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Home Health Care," "Hospice Services," or "Rehabilitative and Habilitative Services" in the "Benefits and Your Cost Share" section

Items and services to correct refractive defects of the eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.

Massage therapy

Massage therapy, except that this exclusion does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Home Health Care," "Hospice Services," or "Rehabilitative and Habilitative Services" in the "Benefits and Your Cost Share" section.

Oral nutrition

Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food.

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section
- Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Benefits and Your Cost Share" section

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility, inpatient respite care covered in the "Hospice Care" section, or residential treatment program Services covered in the "Chemical Dependency Services" and "Mental Health Services" sections.

Routine foot care items and services

Routine foot care items and services that are not Medically Necessary.

Services not approved by the federal Food and Drug Administration

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other Services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S. but are not approved by the FDA. This exclusion applies to Services provided anywhere, even outside the U.S.

This exclusion does not apply to any of the following:

- Services covered under the "Emergency Services and Urgent Care" section that you receive outside the U.S.

- Experimental or investigational Services when an investigational application has been filed with the FDA and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under "Services in Connection with a Clinical Trial" in the "Benefits and Your Cost Share" section

Please refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Services performed by unlicensed people

Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the Member's condition does not require that the services be provided by a licensed health care provider.

This exclusion does not apply to Services covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the "Benefits and Your Cost Share" section.

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service. For example, if you have a noncovered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and we would cover any Services that we would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. A "Surrogacy Arrangement" is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Please refer to "Surrogacy arrangements" under "Reductions" in this "Exclusions, Limitations, Coordination of Benefits, and Reductions" section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and lodging expenses

Travel and lodging expenses, except as described in our Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at **kp.org/specialty-care/travel-reimbursements** or by calling our Member Service Contact Center.

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *DF/EOC*, such as a 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 dispute. Under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest hospital as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, and we will provide coverage and reimbursement as described in that section.

Additional limitations that apply only to a particular benefit are listed in the description of that benefit in this *DF/EOC*.

Coordination of Benefits

The Services covered under this *DF/EOC* are subject to coordination of benefits rules.

Coverage other than Medicare coverage

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

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

give us any information we request to help us coordinate benefits.

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

If you have any questions about coordination of benefits, please call our Member Service Contact Center.

Medicare coverage

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

Reductions

Employer responsibility

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

Government agency responsibility

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

Injuries or illnesses alleged to be caused by third parties

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 "Injuries or illnesses alleged to be caused by third parties" section does not affect your obligation to pay your Cost Share for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph.

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

To secure our rights, we will have a lien on the proceeds of any judgment or settlement you or we obtain against a third party. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred.

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

The Rawlings Group
Subrogation Mailbox
P.O. Box 2000
LaGrange, KY 40031

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

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

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

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers ordinarily charge to the general public ("General Fees"). However, these contracts may allow the providers to recover all or

a portion of the difference between the fees paid by Kaiser Permanente and their General Fees by means of a lien claim under California Civil Code Sections 3045.1–3045.6 against a judgment or settlement that you receive from or on behalf of a third party. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

Medicare benefits

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

Surrogacy arrangements

If you enter into a Surrogacy Arrangement and you or any other payee are entitled to receive payments or other compensation under the Surrogacy Arrangement, you must pay us Charges for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the maximum amount allowed under California Civil Code Section 3040. A "Surrogacy Arrangement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Note: This "Surrogacy arrangements" section does not affect your obligation to pay your Cost Share for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph. After you surrender a baby to the legal parents, you are not obligated to pay Charges for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

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

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

The Rawlings Group
Surrogacy Mailbox
P.O. Box 2000
LaGrange, KY 40031

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce our rights under this "Surrogacy arrangements" section without our prior, written consent.

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

If you have questions about your obligations under this provision, please contact our Member Service Contact Center.

U.S. Department of Veterans Affairs

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

we may recover the value of the Services from the Department of Veterans Affairs.

Workers' compensation or employer's liability benefits

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

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

Post-Service Claims and Appeals

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

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

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

- You want us to cover Services that you have not yet received
- You want us to continue to cover an ongoing course of covered treatment
- You want to appeal a written denial of a request for Services that require prior authorization (as described under "Medical Group authorization procedure for certain referrals")

Who May File

The following people may file claims:

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

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

Supporting Documents

You can request payment or reimbursement orally or in writing. Your request for payment or reimbursement, and any related documents that you give us, constitute your claim.

Claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

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

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers

- By calling our Member Service Contact Center at **1-800-464-4000** or **1-800-390-3510** (TTY users call **711**)

Claims forms for all other Services

To file a claim in writing for all other Services, you may use our Complaint or Benefit Claim/Request form. You can obtain this form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers
- By calling our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**)

Other supporting information

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

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

Initial Claims

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

Submitting a claim for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

If you have received Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services from a Non–Plan Provider, then as soon as possible after you received the Services, you must file your claim by mailing a completed claim form and supporting information to the following address:

Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7004
Downey, CA 90242-7004

Please call our Member Service Contact Center if you need help filing your claim.

Submitting a claim for all other Services

If you have received Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services), then as soon as possible after you receive the Services, you must file your claim in one of the following ways:

- By delivering your claim to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By mailing your claim to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By calling our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Please call our Member Service Contact Center if you need help filing your claim.

After we receive your claim

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

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

- If we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 30 days after we receive your claim
- If we need more information, we will ask you for the information before the end of the initial 30-day decision period. We will send our written decision no later than 15 days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in our letter, we will make our decision based on the information we have within 15 days after the end of that timeframe

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

If you later receive any bills from the Non–Plan Provider for covered Services (other than bills for your Cost Share), please call our Member Service Contact Center for assistance.

Appeals

Claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services from a Non–Plan Provider. If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By mailing your appeal to the Claims Department at the following address:
  Kaiser Foundation Health Plan, Inc.
  Special Services Unit
  P.O. Box 23280
  Oakland, CA 94623
- By calling our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at **kp.org**

Claims for Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services). If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By visiting our website at **kp.org**
- By mailing your appeal to the Member Services Department at a Plan Facility (please refer to *Your Guidebook* for addresses)
- In person from any Member Services office at a Plan Facility and from Plan Providers
- By calling our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**)

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

Additional information regarding a claim for Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services). If we initially denied your request, you must file your appeal within 180 days after the date you received our denial letter. You may send us information including comments, documents, and medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Please send all additional information to the address or fax mentioned in your denial letter.

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

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

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

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

External Review

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

Additional Review

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

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

Dispute Resolution

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

Information about dispute resolution related to pediatric dental coverage is described under "Pediatric Dental Coverage" in the "Introduction" section of this *DF/EOC*.

Grievances

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

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

- You are not satisfied with the quality of care you received
- You received a written denial of Services that require prior authorization from the Medical Group and you want us to cover the Services
- You received a written denial for a second opinion or we did not respond to your request for a second opinion in an expeditious manner, as appropriate for your condition
- Your treating physician has said that Services are not Medically Necessary and you want us to cover the Services
- You were told that Services are not covered and you believe that the Services should be covered
- You want us to continue to cover an ongoing course of covered treatment
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility
- You believe you have faced discrimination from providers, staff, or Health Plan
- We terminated your membership and you disagree with that termination

Who may file

The following people may file a grievance:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a grievance for you by appointing him or her in writing as your authorized representative
- A parent may file for his or her child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the grievance
- A court-appointed guardian may file for his or her ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the grievance
- A court-appointed conservator may file for his or her conservatee

- An agent under a currently effective health care proxy, to the extent provided under state law, may file for his or her principal
- Your physician may act as your authorized representative with your verbal consent to request an urgent grievance as described under "Urgent procedure" in this "Grievances" section

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

How to file

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

To file a grievance in writing, please use our Complaint or Benefit Claim/Request form. You can obtain the form in the following ways:

- By visiting our website at **kp.org**
- In person from any Member Services office at a Plan Facility and from Plan Providers
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)

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

Standard procedure. You must file your grievance in one of the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By mailing your grievance to a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)
- By completing the grievance form on our website at **kp.org**

Please call our Member Service Contact Center if you need help filing a grievance.

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

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

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

Urgent procedure. If you want us to consider your grievance on an urgent basis, please tell us that when you file your grievance.

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

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:
  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 23170
  Oakland, CA 94623-0170
- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (please refer to *Your Guidebook* for addresses)
- By completing the grievance form on our website at **kp.org**

We will decide whether your grievance is urgent or non-urgent unless your attending health care provider tells us your grievance is urgent. If we determine that your grievance is not urgent, we will use the procedure

described under "Standard procedure" in this "Grievances" section. Generally, a grievance is urgent only if one of the following is true:

- Using the standard procedure could seriously jeopardize your life, health, or ability to regain maximum function
- Using the standard procedure would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment
- A physician with knowledge of your medical condition determines that your grievance is urgent

If your grievance involves a request to obtain a nonformulary prescription drug and we respond to your request on an urgent basis, we will notify you of our decision within 24 hours of your request. If we do not decide in your favor, our letter will explain why and describe your further appeal rights. For information on how to request a review by an independent review organization, see "Independent Review Organization for Nonformulary Prescription Drug Requests" in this "Dispute Resolution" section.

For all other grievances that we respond to on an urgent basis, we will give you oral notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your grievance. We will send you a written confirmation of our decision within 3 days after we received your grievance.

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

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

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

Additional information regarding pre-service requests for Medically Necessary Services. You may give testimony in writing or by telephone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by telephone, you should call the phone number mentioned in our acknowledgment letter.

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

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

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

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

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

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

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

decision letter, that decision will be based on the information in your appeal file.

Independent Review Organization for Nonformulary Prescription Drug Requests

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

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

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:
  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 23170
  Oakland, CA 94623-0170
- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (please refer to Your Guidebook for addresses)
- By completing the grievance form on our website at **kp.org**

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

Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll free at **1-800-464-4000** (TTY users call **711**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR).
If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet website **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review (IMR)

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

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

- One of these situations applies to you:
  - you have a recommendation from a provider requesting Medically Necessary Services
  - you have received Emergency Services, emergency ambulance Services, or Urgent Care from a provider who determined the Services to be Medically Necessary
  - you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary

- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for urgent grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function. If we have denied your grievance, you must submit your request for an IMR within six months of the date of our written denial. However, the DMHC may accept your request after six months if they determine that circumstances prevented timely submission

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

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

Experimental or investigational denials

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

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

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

Office of Civil Rights Complaints

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

You may file your complaint with the OCR within 180 days of when you believe the act of discrimination occurred. However, the OCR may accept your request after six months if they determine that circumstances prevented timely submission. For more information on the OCR and how to file a complaint with the OCR, go to **hhs.gov/civil-rights**.

Additional Review

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

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

and church plans), you may have a right to request review in state court

Binding Arbitration

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

Scope of arbitration

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

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

Members enrolled under this *DF/EOC* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

As referred to in this "Binding Arbitration" section, "Member Parties" include:

- A Member
- A Member's heir, relative, or personal representative
- Any person claiming that a duty to him or her arises from a Member's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- KP Cal, LLC
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any Southern California Permanente Medical Group or The Permanente Medical Group physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties
- Any employee or agent of any of the foregoing

"Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

Rules of Procedure

Arbitrations shall be conducted according to the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure") developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from our Member Service Contact Center.

Initiating arbitration

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

Serving Demand for Arbitration

Health Plan, Kaiser Foundation Hospitals, KP Cal, LLC, The Permanente Medical Group, Inc., Southern

California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc.
Legal Department
393 E. Walnut St.
Pasadena, CA 91188

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing fee

The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling our Member Service Contact Center.

Number of arbitrators

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (see the Rules of Procedure).

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of arbitrators' fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the Rules of Procedure. In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

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

General provisions

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

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

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the

time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2018, your last minute of coverage was at 11:59 p.m. on December 31, 2017). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *DF/EOC* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section.

Information about termination of pediatric dental coverage is described under "Pediatric Dental Coverage" in the "Introduction" section of this *DF/EOC*.

Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, your Group will notify you of the date that your membership will end. Your membership termination date is the first day you are not covered. For example, if your termination date is January 1, 2018, your last minute of coverage was at 11:59 p.m. on December 31, 2017.

Termination of *Agreement*

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Termination for Cause

If you intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider, we may terminate your membership by sending written notice to the Subscriber; termination will be effective 30 days from the date we send the notice. Some examples of fraud include:

- Misrepresenting eligibility information about you or a Dependent
- Presenting an invalid prescription or physician order
- Misusing a Kaiser Permanente ID card (or letting someone else use it)
- Giving us incorrect or incomplete material information. For example, you have entered into a Surrogacy Arrangement and you fail to send us the information we require under "Surrogacy arrangements" under "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section
- Failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits

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

Termination of a Product or all Products

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

Payments after Termination

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

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Emergency Services and Urgent Care" and "Dispute Resolution" sections

We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you.

State Review of Membership Termination

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

Continuation of Membership

If your membership under this *DF/EOC* ends, you may be eligible to continue Health Plan membership without a break in coverage. You may be able to continue Group coverage under this *DF/EOC* as described under "Continuation of Group Coverage." Also, you may be able to continue membership under an individual plan as described under "Continuation of Coverage under an Individual Plan." If at any time you become entitled to continuation of Group coverage, please examine your coverage options carefully before declining this coverage. Individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

Continuation of Group coverage under this *DF/EOC* also includes continuation of coverage under the attached Delta Dental DF/EOC.

Continuation of Group Coverage

COBRA

You may be able to continue your coverage under this *DF/EOC* for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law (the Consolidated Omnibus Budget Reconciliation Act). COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

If you enroll in COBRA and exhaust the time limit for COBRA coverage, you may be able to continue Group coverage under state law as described under "Cal-COBRA" in this "Continuation of Group Coverage" section.

Cal-COBRA

If you are eligible for Cal-COBRA, you can continue coverage as described in this "Cal-COBRA" section if you apply for coverage in compliance with Cal-COBRA law and pay applicable Premiums.

Eligibility and effective date of coverage for Cal-COBRA after COBRA. If your group is subject to COBRA and your COBRA coverage ends, you may be able to continue Group coverage effective the date your COBRA coverage ends if all of the following are true:

- Your effective date of COBRA coverage was on or after January 1, 2003
- You have exhausted the time limit for COBRA coverage and that time limit was 18 or 29 months
- You do not have Medicare

You must request an enrollment application by calling our Member Service Contact Center within 60 days of the date of when your COBRA coverage ends.

Eligibility and effective date of coverage for Cal-COBRA when your coverage is through a small employer. If your group is not subject to COBRA, you may be able to continue uninterrupted Group coverage under this *DF/EOC* if all of the following are true:

- Your employer meets the definition of "small employer" in Section 1357 of the California Health and Safety Code
- Your employer employed between 2 to 19 eligible employees on at least 50 percent of its working days during the last calendar year
- You do not have Medicare Part A
- You experience one of the following qualifying events:
  - your coverage is through a Subscriber who dies, divorces, legally separates, or gets Medicare
  - you no longer qualify as a Dependent, under the terms of the "Who Is Eligible" section of this *DF/EOC*
  - you are a Subscriber, or your coverage is through a Subscriber, whose employment terminates (other than for gross misconduct) or whose hours of employment are reduced

You must request an enrollment application by calling our Member Service Contact Center within 60 days of the date of a qualifying event described above.

Cal-COBRA enrollment and Premiums. Within 10 days of your request for an enrollment application, we will send you our application, which will include Premium and billing information. You must return your completed application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay the bill within 45 days after the date we issue the bill. The first Premium payment will include coverage from your Cal-COBRA effective date through our current billing cycle. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

After that first payment, your Premium payment for the upcoming coverage month is due on first day of that month. The Premiums will not exceed 110 percent of the applicable Premiums charged to a similarly situated individual under the Group benefit plan except that Premiums for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent instead of 110 percent. Returned checks or insufficient funds on electronic payments will be subject to a $25 fee.

Changes to Cal-COBRA coverage and Premiums. Your Cal-COBRA coverage is the same as for any similarly situated individual under your Group's *Agreement*, and your Cal-COBRA coverage and Premiums will change at the same time that coverage or Premiums change in your Group's *Agreement*. Your Group's coverage and Premiums will change on the renewal date of its *Agreement* (January 1), and may also change at other times if your Group's *Agreement* is amended. Your monthly invoice will reflect the current Premiums that are due for Cal-COBRA coverage, including any changes. For example, if your Group makes a change that affects Premiums retroactively, the amount we bill you will be adjusted to reflect the retroactive adjustment in Premiums. Your Group can tell you whether this *DF/EOC* is still in effect and give you a current one if this *DF/EOC* has expired or been amended. You can also request one from our Member Service Contact Center.

Cal-COBRA open enrollment or termination of another health plan. If you previously elected Cal-COBRA coverage through another health plan available through your Group, you may be eligible to enroll in Kaiser Permanente during your Group's annual open enrollment period, or if your Group terminates its agreement with the health plan you are enrolled in. You will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA. Please ask your Group for information about health plans available to you either at open enrollment or if your Group terminates a health plan's agreement.

In order for you to switch from another health plan and continue your Cal-COBRA coverage with us, we must receive your enrollment application during your Group's open enrollment period, or within 63 days of receiving the Group's termination notice described under "Group responsibilities." To request an application, please call our Member Service Contact Center. We will send you our enrollment application and you must return your completed application before open enrollment ends or within 63 days of receiving the termination notice described under "Group responsibilities." If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay the bill within 45 days after the date we issue the bill. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

How you may terminate your Cal-COBRA coverage. You may terminate your Cal-COBRA coverage by sending written notice, signed by the Subscriber, to the address below. Your membership will terminate at 11:59 p.m. on the last day of the month in which we receive your notice. Also, you must include with your notice all amounts payable related to your Cal-COBRA coverage, including Premiums, for the period prior to your termination date.

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 23127
San Diego, CA 92193-3127

Termination for nonpayment of Cal-COBRA Premiums. If you do not pay your required Premiums by the due date, we may terminate your membership as described in this "Termination for nonpayment of Cal-COBRA Premiums" section. If you intend to terminate your membership, be sure to notify us as described under "How you may terminate your Cal-COBRA coverage" in this "Cal-COBRA" section, as you will be responsible for any Premiums billed to you unless you let us know before the first of the coverage month that you want us to terminate your coverage.

Your Premium payment for the upcoming coverage month is due on the first day of that month. If we do not

receive full Premium payment on or before the first day of the coverage month, we will send a notice of nonreceipt of payment (a "Late Notice") to the Subscriber's address of record. This Late Notice will include the following information:

- A statement that we have not received full Premium payment and that we will terminate the memberships of everyone in your Family for nonpayment if we do not receive the required Premiums within 30 days after the date of the Late Notice
- The amount of Premiums that are due
- The specific date and time when the memberships of everyone in your Family will end if we do not receive the Premiums

If we terminate your Cal-COBRA coverage because we did not receive the required Premiums when due, your membership will end at 11:59 p.m. on the 30th day after the date of the Late Notice. Your coverage will continue during this 30 day grace period, but upon termination you will be responsible for paying all past due Premiums, including the Premiums for this grace period.

We will mail a Termination Notice to the Subscriber's address of record if we do not receive full Premium payment within 30 days after the date of the Late Notice. The Termination Notice will include the following information:

- A statement that we have terminated the memberships of everyone in your Family for nonpayment of Premiums
- The specific date and time when the memberships of everyone in your Family ended
- The amount of Premiums that are due
- Information explaining whether or not you can reinstate your memberships
- Your appeal rights

If we terminate your membership, you are still responsible for paying all amounts due.

Reinstatement of your membership after termination for nonpayment of Cal-COBRA Premiums. If we terminate your membership for nonpayment of Premiums, we will permit reinstatement of your membership three times during any 12-month period if we receive the amounts owed within 15 days of the date of the Termination Notice. We will not reinstate your membership if you do not obtain reinstatement of your terminated membership within the required 15 days, or if we terminate your membership for nonpayment of Premiums more than three times in a 12-month period.

Termination of Cal-COBRA coverage. Cal-COBRA coverage continues only upon payment of applicable monthly Premiums to us at the time we specify, and terminates on the earliest of:

- The date your Group's *Agreement* with us terminates (you may still be eligible for Cal-COBRA through another Group health plan)
- The date you get Medicare
- The date your coverage begins under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have (or that does contain such an exclusion or limitation, but it has been satisfied)
- The date you become covered, or could have become covered, under COBRA
- Either the date that is 36 months after the date of your original Cal-COBRA qualifying event or the date that is 36 months after the date of your original COBRA effective date (under this or any other plan) if you were enrolled in COBRA before Cal-COBRA
- The date your membership is terminated for nonpayment of Premiums as described under "Termination for nonpayment of Cal-COBRA Premiums" in this "Continuation of Membership" section

Note: If the Social Security Administration determined that you were disabled at any time during the first 60 days of COBRA coverage, you must notify your Group within 60 days of receiving the determination from Social Security. Also, if Social Security issues a final determination that you are no longer disabled in the 35th or 36th month of Group continuation coverage, your Cal-COBRA coverage will end the later of: (1) expiration of 36 months after your original COBRA effective date, or (2) the first day of the first month following 31 days after Social Security issued its final determination. You must notify us within 30 days after you receive Social Security's final determination that you are no longer disabled.

Group responsibilities. Your Group is required to give Health Plan written notice within 30 days after a Subscriber is no longer eligible for coverage due to termination of employment or reduction of hours. If your Group prefers that we not offer Cal-COBRA coverage because your Group terminated a Subscriber's employment for gross misconduct, your Group must send written notice within five days after the Subscriber's employment terminates to:

Kaiser Foundation Health Plan
California Service Center

P.O. Box 23059
San Diego, CA 92193-3059

Your Group is required to notify us in writing within 30 days if your Group becomes subject to COBRA under federal law.

If your Group's agreement with a health plan is terminated, your Group is required to provide written notice at least 30 days before the termination date to the persons whose Cal-COBRA coverage is terminating. This notice must inform Cal-COBRA beneficiaries that they can continue Cal-COBRA coverage by enrolling in any health benefit plan offered by your Group. It must also include information about benefits, premiums, payment instructions, and enrollment forms (including instructions on how to continue Cal-COBRA coverage under the new health plan). Your Group is required to send this information to the person's last known address, as provided by the prior health plan. Health Plan is not obligated to provide this information to qualified beneficiaries if your Group fails to provide the notice. These persons will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this *DF/EOC* for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group to find out how to elect USERRA coverage and how much you must pay your Group.

Coverage for a Disabling Condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates and is not renewed, we will cover Services for your totally disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's *Agreement* with us terminated
- You are no longer Totally Disabled
- Your Group's *Agreement* with us is replaced by another group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this *DF/EOC*, including Cost Share, but we will not cover Services for any condition other than your totally disabling condition.

For Subscribers and adult Dependents, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in any employment or occupation, even with training, education, and experience.

For Dependent children, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

To request continuation of coverage for your disabling condition, you must call our Member Service Contact Center within 30 days after your Group's *Agreement* with us terminates.

Continuation of Coverage under an Individual Plan

If you want to remain a Health Plan member when your Group coverage ends, you might be able to enroll in one of our Kaiser Permanente for Individuals and Families plans. The premiums and coverage under our individual plan coverage are different from those under this *DF/EOC*.

If you want your individual plan coverage to be effective when your Group coverage ends, you must submit your application within the special enrollment period for enrolling in an individual plan due to loss of other coverage. Otherwise, you will have to wait until the next annual open enrollment period.

To request an application to enroll directly with us, please go to **kp.org** or call our Member Service Contact Center. For information about plans that are available through Covered California, see "Covered California" below.

Covered California

U.S. citizens or legal residents of the U.S. can buy health care coverage from Covered California. This is California's health insurance marketplace (the Exchange). You may apply for help to pay for premiums and copayments but only if you buy coverage through Covered California. This financial assistance may be available if you meet certain income guidelines. To learn more about coverage that is available through Covered California, visit **CoveredCA.com** or call Covered California at **1-800-300-1506** (TTY users call **711**).

Miscellaneous Provisions

Administration of *Agreement*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of your Group's *Agreement*, including this *DF/EOC*.

Advance Directives

The California Health Care Decision Law offers several ways for you to control the kind of health care you will receive if you become very ill or unconscious, including the following:

- A *Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your own views on life support and other treatments
- *Individual health care instructions* let you express your wishes about receiving life support and other treatment. You can express these wishes to your doctor and have them documented in your medical chart, or you can put them in writing and have that included in your medical chart

To learn more about advance directives, including how to obtain forms and instructions, contact the Member Services Department at a Plan Facility. You can also refer to *Your Guidebook* for more information about advance directives.

Agreement Binding on Members

By electing coverage or accepting benefits under this *DF/EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *DF/EOC*.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *DF/EOC*, your Group is required to inform you in accord with applicable law and your Group's *Agreement.*

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *DF/EOC*.

Assignment

You may not assign this *DF/EOC* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

Attorney and Advocate Fees and Expenses

In any dispute between a Member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses.

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *DF/EOC* and we have the discretionary authority to review and evaluate claims that arise under this *DF/EOC*. We conduct this evaluation independently by interpreting the provisions of this *DF/EOC*. We may use medical experts to help us review claims. If coverage under this *DF/EOC* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *DF/EOC*.

ERISA Notices

This "ERISA Notices" section applies only if your Group's health benefit plan is subject to the Employee Retirement Income Security Act (ERISA). We provide these notices to assist ERISA-covered groups in complying with ERISA. Coverage for Services described in these notices is subject to all provisions of this *DF/EOC*.

Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Share applicable to other medical and surgical benefits provided under this plan.

Governing Law

Except as preempted by federal law, this *DF/EOC* will be governed in accord with California law and any provision that is required to be in this *DF/EOC* by state or federal law shall bind Members and Health Plan whether or not set forth in this *DF/EOC*.

Group and Members Not Our Agents

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

No Waiver

Our failure to enforce any provision of this *DF/EOC* will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Nondiscrimination

We do not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Notices Regarding Your Coverage

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

Note: When we tell your Group about changes to this *DF/EOC* or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days (or five days if we terminate your Group's *Agreement*) after receiving the information from us.

Overpayment Recovery

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

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information. Your protected health information is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your

protected health information. You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means.

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

This is only a brief summary of some of our key privacy practices. OUR *NOTICE OF PRIVACY PRACTICES*, WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY PRACTICES AND YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION, IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. To request a copy, please call our Member Service Contact Center. You can also find the notice at a Plan Facility or on our website at **kp.org**.

Public Policy Participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. A list of the Board of Directors is available on our website at **kp.org** or from our Member Service Contact Center. If you would like to provide input about Health Plan public policy for consideration by the Board, please send written comments to:

Kaiser Foundation Health Plan, Inc.
Office of Board and Corporate Governance Services
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Helpful Information

How to Obtain this *DF/EOC* in Other Formats

You can request a copy of this *DF/EOC* in an alternate format (Braille, audio, electronic text file, or large print) by calling our Member Service Contact Center.

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

Please refer to *Your Guidebook* for helpful information about your coverage, such as:

- The location of Plan Facilities in your area and the types of covered Services that are available from each facility
- How to use our Services and make appointments
- Hours of operation
- Appointments and advice phone numbers

Your Guidebook provides other important information, such as preventive care guidelines and your Member rights and responsibilities. *Your Guidebook* is subject to change and is periodically updated. You can get a copy of *Your Guidebook* by visiting our website at **kp.org** or by calling our Member Service Contact Center.

Online Tools and Resources

Here are some tools and resources available on our website at **kp.org**:

- A directory of Plan Facilities and Plan Physicians
- Tools you can use to email your doctor's office, view test results, refill prescriptions, and schedule routine appointments
- Health education resources
- Appointments and advice phone numbers

You can also access tools and resources using the KP app on your smartphone or other mobile device.

How to Reach Us

Appointments

If you need to make an appointment, please call us or visit our website:

Call The appointment phone number at a Plan Facility (refer to *Your Guidebook* or the

facility directory on our website at **kp.org** for phone numbers)

Website **kp.org** for routine (non-urgent) appointments with your personal Plan Physician or another Primary Care Physician

Not sure what kind of care you need?

If you need advice on whether to get medical care, or how and when to get care, we have licensed health care professionals available to assist you by phone 24 hours a day, 7 days a week:

Call The appointment or advice phone number at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for phone numbers)

Member Services

If you have questions or concerns about your coverage, how to obtain Services, or the facilities where you can receive care, you can reach us in the following ways:

Call **1-800-464-4000** (English)
1-800-788-0616 (Spanish)
1-800-757-7585 (Chinese dialects)
TTY users call **711**

24 hours a day, seven days a week (except closed holidays)

Visit Member Services Department at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for addresses)

Write Member Services Department at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for addresses)

Website **kp.org**

Estimates, bills, and statements

For the following concerns, please call us at the number below:

- If you have questions about a bill
- To find out how much you have paid toward your Plan Deductible (if applicable) or Plan Out-of-Pocket Maximum
- To get an estimate of Charges for Services that are subject to the Plan Deductible (if applicable)

Call **1-800-390-3507** (TTY users call **711**)

Monday through Friday 7 a.m. to 5 p.m.

Website **kp.org/memberestimates**

Away from home travel line

If you have questions about your coverage when you are away from home:

Call **951-268-3900**

24 hours a day, seven days a week (except closed holidays)

Website **kp.org/travel**

Authorization for Post-Stabilization Care

To request prior authorization for Post-Stabilization Care as described under "Emergency Services" in the "Emergency Services and Urgent Care" section:

Call **1-800-225-8883** or the notification telephone number on your Kaiser Permanente ID card (TTY users call **711**)

24 hours a day, seven days a week

Help with claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

If you need a claim form to request payment or reimbursement for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits and Your Cost Share" section, or if you need help completing the form, you can reach us by calling or by visiting our website.

Call **1-800-464-4000** or **1-800-390-3510** (TTY users call **711**)

24 hours a day, seven days a week (except closed holidays)

Website **kp.org**

Submitting claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

If you need to submit a completed claim form for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits and Your Cost Share" section, or if you need to submit other information that we request about your claim, send it to our Claims Department:

Write Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 7004
Oakland, CA 90242-7004

Telephone access (TTY)

If you use a text telephone device (TTY, also known as TDD) to communicate by phone, you can use the California Relay Service by calling **711**.

Interpreter services

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

Payment Responsibility

This "Payment Responsibility" section briefly explains who is responsible for payments related to the health care coverage described in this *DF/EOC.* Payment responsibility is more fully described in other sections of the *DF/EOC* as described below:

- Your Group is responsible for paying Premiums, except that you are responsible for paying Premiums if you have COBRA or Cal-COBRA (refer to "Premiums" in the "Premiums, Eligibility, and Enrollment" section and "COBRA" and "Cal-COBRA" under "Continuation of Group Coverage" in the "Continuation of Membership" section)
- Your Group may require you to contribute to Premiums (your Group will tell you the amount and how to pay)
- You are responsible for paying your Cost Share for covered Services (refer to "Your Cost Share" in the "Benefits and Your Cost Share" section)
- If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider, or if you receive emergency ambulance Services, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us (refer to "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)
- If you receive Services from Non–Plan Providers that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services) and you want us to pay for the care, you must submit a grievance (refer to "Grievances" in the "Dispute Resolution" section)
- If you have coverage with another plan or with Medicare, we will coordinate benefits with the other coverage (refer to "Coordination of Benefits" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- In some situations, you or a third party may be responsible for reimbursing us for covered Services (refer to "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- You must pay the full price for noncovered Services

DeltaCare® USA

DeltaCare® USA Children's Dental HMO

This is a pediatric-only dental benefit

Provided by:

Delta Dental of California
100 First Street
San Francisco, California 94105

Administered by:

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, Georgia 30023
800-589-4618

deltadentalins.com

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IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at the Member/Customer Service telephone number on the back of your Delta Dental ID card, or 1-800-589-4618.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda gratuita, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Delta Dental o al 1-800-589-4618.

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以用您所講的語言書寫。如需幫助，請立即撥打登列在您的Delta Dental ID卡背面上的會員/客戶服務部的電話，或者撥打電話 1-800-589-4618.

INTRODUCTION

We are pleased to welcome you to the DeltaCare® USA dental plan. The Contractholder (see Definitions) has selected Delta Dental of California ("Delta Dental") to meet your dental insurance needs. This plan is underwritten by Delta Dental and administered by Delta Dental Insurance Company.

IMPORTANT NOTE: This dental plan is being offered in conjunction with a medical plan underwritten by Kaiser Foundation Health Plan, Inc. A description of your medical plan benefits is attached to this dental plan. If you have questions regarding your medical plan coverage, please contact Kaiser Foundation Health Plan, Inc. at 1-800-464-4000 (TTY users call 711).

Our goal is to provide you with the highest quality dental care and to help you maintain good dental health. We encourage you not to wait until you have a problem to see the Dentist but to see him or her on a regular basis.

Eligibility is determined by the Medical Plan Issuer. The plan provides dental Benefits as defined in the following section:

- ***Eligibility Requirement for Pediatric Benefits*** **(Essential Health Benefits)**

Using This Combined Evidence of Coverage and Disclosure Form (EOC)

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS DENTAL CARE MAY BE OBTAINED.

This EOC, including Attachments, discloses the terms and conditions of your coverage and is designed to help you make the most of your dental plan. It will help you understand how the plan works and how to obtain dental care. Please read this EOC completely and carefully. Keep in mind that "you" and "your" mean the individuals who are covered. "We," "us" and "our" always refer to Delta Dental or the Administrator. In addition, please read the "*Definitions"* section as it will explain any words with special or technical meanings. Persons with Special Health Care Needs should read the section entitled "Special Needs."

Identification Number

Please provide the Enrollee's identification ("ID") number to your Dentist whenever you receive dental services. ID cards are not required. If you wish to have an ID card, you may obtain one by visiting our website at deltadentalins.com.

This EOC is *not* a Summary Plan Description to meet the requirements of ERISA.

Contract - The Benefit explanations contained in this EOC are subject to all provisions of the Contract on file with the Contractholder and do not modify the terms and conditions of the Contract in any way. A copy of the Contract will be furnished to you upon request. Any direct conflict between the Contract and the EOC will be resolved according to the terms which are most favorable to you.

Contact Us - For more information, please visit our website at deltadentalins.com or call our Customer Service Center at 800-589-4618. If you prefer to write us with your question(s), please mail your inquiry to the following address:

DeltaCare USA Customer Service
P.O. Box 1803
Alpharetta, GA 30023

Anthony S. Barth, President

NOTICE: THIS EOC CONSTITUTES ONLY A SUMMARY OF YOUR GROUP DENTAL PROGRAM. AS REQUIRED BY THE CALIFORNIA HEALTH & SAFETY CODE, THIS IS TO ADVISE YOU THAT THE CONTRACT MUST BE CONSULTED TO DETERMINE THE EXACT TERMS AND CONDITIONS OF COVERAGE. THIS INFORMATION IS NOT A GUARANTEE OF COVERED BENEFITS, SERVICES OR PAYMENTS.

A STATEMENT DESCRIBING DELTA DENTAL'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

DEFINITIONS

The following are definitions of words that have special or technical meanings under this EOC.

Accumulation Period: a period of time of at least 12 consecutive months for purposes of accumulating amounts toward your Out-of-Pocket Maximum. Your Accumulation Period may be a calendar year, a contract year, or some other period determined by the Contractholder. Your Accumulation Period is specified in your MPI *Evidence of Coverage*.

Administrator: Delta Dental Insurance Company or other entity designated by Delta Dental, operating as an Administrator in the state of California. Certain functions described throughout this EOC may be performed by the Administrator, as designated by Delta Dental. The mailing address for the Administrator is P.O. Box 1803, Alpharetta, GA 30023. The Administrator will answer calls directed to 800-589-4618.

Authorization: the process by which Delta Dental determines if a procedure or treatment is a referable Benefit under the Enrollee's plan.

Benefits: covered pediatric dental services provided under the terms of the Contract and as described in this EOC.

Contract: the agreement between Delta Dental and the Contractholder, including any Attachments, pursuant to which Delta Dental has issued this EOC.

Contract Dentist: a Dentist who provides services in general dentistry and who has agreed to provide Benefits under the plan.

Contract Orthodontist: a Dentist who specializes in orthodontics and who has agreed to provide Benefits under the plan, which covers medically necessary orthodontics.

Contract Specialist: a Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under the plan.

Contract Term: the period during which the Contract is in effect.

Contractholder: an employer that has contracted for Benefits under this plan.

Copayment: the amount listed in the Schedules and charged to an Enrollee by a Contract Dentist, Contract Orthodontist, or Contract Specialist for the Benefits provided under the plan. Copayments must be paid at the time treatment is received.

Dentist: a duly licensed Dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

Effective Date: the original date the Packaged Offering starts. The date is given in the MPI *Evidence of Coverage*.

Eligible Pediatric Individual: a person who is eligible to enroll for pediatric dental Benefits as described in this EOC and the MPI *Evidence of Coverage*. Eligible Pediatric Individuals are children from birth through the end of the contract year in which the child turns 19 who meet the eligibility requirements in the MPI *Evidence of Coverage*.

Emergency Services: care provided by a Dentist to treat a dental condition which manifests as a symptom of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected by the Enrollee to result in either: 1) placing the Enrollee's dental health in serious jeopardy, or 2) serious impairment to dental functions.

Employee: an individual employed by the Contractholder who has opted to enroll Eligible Pediatric Individuals as described in this EOC and the MPI Evidence of Coverage.

Enrollee: an Eligible Pediatric Individual ("Pediatric Enrollee") enrolled to receive Benefits.

Enrollee Effective Date: the date the MPI reports coverage will begin for each Enrollee.

Essential Health Benefits ("Pediatric Benefits"): for the purposes of this EOC, Essential Health Benefits are certain pediatric oral services that are required to be included under the Affordable Care Act. The services considered to be Essential Health Benefits are determined by state and federal agencies and are available for Eligible Pediatric Individuals.

Medical Plan Issuer ("MPI"): entity providing the medical plan that is issued and delivered to the Contractholder with this dental plan as a Packaged Offering. For purposes of this EOC, the MPI is Kaiser Foundation Health Plan, Inc.

Open Enrollment Period: the period of the year that the MPI has established when Employees may change coverage selections for the next Contract Term.

Optional: any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure, is chosen by the Enrollee and is subject to the limitations and exclusions described in the Schedules attached to this EOC.

Out-of-Network: treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits under the terms of the Contract.

Out-of-Pocket Maximum: the maximum amount that a Pediatric Enrollee must satisfy for Benefits during the Accumulation Period. Refer to Schedule A attached to this EOC for details.

Packaged Offering: the combination of a separate medical plan provided by the MPI and this dental plan provided by Delta Dental.

Pediatric Benefits: See definition of Essential Health Benefits above.

Procedure Code: the Current Dental Terminology (CDT®) number assigned to a Single Procedure by the American Dental Association.

Reasonable: an Enrollee exercises prudent judgment in determining that a dental emergency exists and makes at least one attempt to contact his/her Contract Dentist to obtain Emergency Services and, in the event the Dentist is not available, makes at least one attempt to contact Delta Dental for assistance before seeking care from another Dentist.

Single Procedure: a dental procedure that is assigned a separate Procedure Code.

Special Health Care Need: a physical or mental impairment, limitation or condition that substantially interferes with an Enrollee's ability to obtain Benefits. Examples of such a Special Health Care Need are 1) the Enrollee's inability to obtain access to the assigned Contract Dentist's facility because of a physical disability and 2) the Enrollee's inability to comply with the Contract Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

Specialist Services: services performed by a Dentist who specializes in the practice of oral surgery, endodontics, periodontics, orthodontics (if medically necessary) or pediatric dentistry. Specialist Services must be authorized by Delta Dental.

Spouse: a person related to or a partner of the Employee:

- as defined and as may be required to be treated as a Spouse by the laws of the state where the Contract is issued and delivered; or
- as defined and as may be required to be treated as a Spouse by the laws of the state where the Employee resides; or
- as may be recognized by the Contractholder.

Treatment in Progress: any single dental procedure, as defined by the CDT Code that has been started while the Enrollee was eligible to receive Benefits, and for which multiple appointments are necessary to complete the procedure whether or not the Enrollee continues to be eligible for Benefits under the DeltaCare USA plan. Examples include: teeth that have been prepared for crowns, root canals where a working length has been established, full or partial dentures for which an impression has been taken and orthodontics when bands have been placed and tooth movement has begun.

ELIGIBILITY AND ENROLLMENT

The MPI is responsible for establishing eligibility and reporting enrollment to us. The MPI is also responsible for administering any required continuation under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), the Family & Medical Leave Act of 1993, the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and continuation of coverage under the California Continuation Benefits Replacement Act of 1997 ("Cal-COBRA"). We process enrollment as reported by the MPI.

This EOC includes Pediatric Benefits.

Eligibility Requirement for Pediatric Benefits

Enrollees eligible for Pediatric Benefits are:

- an Employee; and/or
- an Employee's Spouse and dependent children

who meet the eligibility requirements as described in the MPI Evidence of Coverage.

Enrollment

You may be required to contribute towards the cost of coverage for Pediatric Enrollees. The MPI is responsible for establishing an Enrollee's Effective Date for enrollment.

Enrollees in the medical plan provided by the MPI are required to enroll under this dental plan. Enrollment under this dental plan for coverage begins on the date enrollment under the medical plan begins and terminates on the date that enrollment under the medical plan terminates.

Termination of Coverage

An Enrollee's coverage is terminated:

- on the date reported by the MPI;
- if MPI terminated the Packaged Offering; or
- if he or she is no longer eligible through the MPI.

Please refer to your MPI Evidence of Coverage for further information regarding renewal and termination of this dental plan.

We will not pay for services received after the Enrollee's coverage ends. However for Treatment in Progress, we will continue to provide Benefits less any applicable Copayment.

An Enrollee and/or Contractholder who believes that coverage has been, or will be, improperly cancelled, rescinded or not renewed may request a review by the Director of the California Department of Managed Health Care in accordance with Section 1365(b) of the California Health and Safety Code.

OVERVIEW OF DENTAL BENEFITS

This section provides information that will give you a better understanding of how the dental plan works and how to make it work best for you.

What is the DeltaCare USA Plan?

The DeltaCare USA Plan provides Pediatric Benefits through a convenient network of Contract Dentists in the state of California. These Dentists are screened to ensure that our standards of quality, access and safety are maintained. The network is composed of established dental professionals. When you visit your assigned Contract Dentist, you pay only the applicable Copayment for Benefits. There are no deductibles, lifetime maximums or claim forms.

Benefits, Limitations and Exclusions

This plan provides the Benefits described in the Schedules that are a part of this EOC. Except for some Emergency Services, benefits are only available in the state of California. The services are performed as deemed appropriate by your attending Contract Dentist.

Copayments and Other Charges

You are required to pay any Copayments listed in the Schedules attached to this EOC. Copayments are paid directly to the Dentist who provides treatment. Charges for broken appointments and visits after normal visiting hours are listed in the Schedules attached to this EOC.

In the event that we fail to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by us. By statute, the DeltaCare USA provider contract contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by Delta Dental. Except for the provisions in "*Emergency Services", if* you have not received Authorization for treatment from an Out-of-Network Dentist, and we fail to pay that Out-of-Network Dentist, you may be liable to that Dentist for the cost of services. For further clarification, see "*Emergency Services"* and *"Specialist Services."*

Non-Covered Services

IMPORTANT: If you opt to receive dental services that are not covered services under this plan, a Contract Dentist may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the Dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call Customer Service at 800-589-4618. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

Coordination of Benefits

We coordinate the Benefits under this EOC with your benefits under any other group or pre-paid plan or insurance policy designed to fully integrate with other plans. If this plan is the "primary" plan, we will not reduce Benefits, but if this plan is the "secondary" plan, we determine Benefits after those of the primary plan and will pay the lesser of the amount that we would pay in the absence of any other dental benefit coverage or the Enrollee's total out-of-pocket cost under the primary plan for Benefits covered under this EOC.

How do we determine which Plan is the "primary" plan?

(1) The plan covering the Enrollee as an employee is primary over a plan covering the Enrollee as a dependent.

(2) The plan covering the Enrollee as an employee is primary over a plan covering the insured person as a dependent. However, if the insured person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is secondary to the plan covering the insured person as a dependent; and primary to the plan covering the insured person as other than a dependent (e.g. a retired employee), then the benefits of the plan covering the insured person as a dependent are determined before those of the plan covering that insured person as other than a dependent.

(3) Except as stated in paragraph (4), when this plan and another plan cover the same child as a dependent of different persons, called parents:

a) the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in that year; but

b) if both parents have the same birthday, the benefits of the plan covering one parent longer are determined before those of the plan covering the other parent for a shorter period of time.

c) However, if the other plan does not have the birthday rule described above, but instead has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan determines the order of benefits.

(4) In the case of a dependent child of legally separated or divorced parents, the plan covering the Enrollee as a dependent of the parent with legal custody or as a dependent of the custodial parent's Spouse (i.e. step-parent) will be primary over the plan covering the Enrollee as a dependent of the parent without legal custody. If there is a court decree establishing financial responsibility for the health care expenses with respect to the child, the benefits of a plan covering the child as a dependent of the parent with such financial responsibility will be determined before the benefits of any other policy covering the child as a dependent child.

(5) If the specific terms of a court decree state that the parents will share joint custody without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child will follow the order of benefit determination rules outlined in paragraph (3).

(6) The benefits of a plan covering an insured person as an employee who is neither laid-off nor retired are determined before those of a plan covering that insured person as a laid-off or retired employee. The same would hold true if an insured person is a dependent of a person covered as a retiree or an employee. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (6) is ignored.

(7) If an insured person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following will be the order of benefit determination.

a) First, the benefits of a plan covering the insured person as an employee (or as that insured person's dependent).

b) Second, the benefits under the continuation coverage.

c) If the other plan does not have the rule described above, and if, as a result, the plans do not agree on the order of benefits, this rule (7) is ignored.

(8) If none of the above rules determines the order of benefits, the benefits of the plan covering an employee longer are determined before those of the plan covering that insured person for the shorter term.

(9) When determination cannot be made in accordance with the above for Pediatric Benefits, the benefits of a plan that is a medical plan covering dental as a benefit shall be primary to a dental only plan.

HOW TO USE THE DELTACARE USA PLAN/CHOICE OF CONTRACT DENTIST

Delta Dental shall provide Contract Dentists at convenient locations. Upon enrollment, Delta Dental will assign the Enrollee to a Contract Dentist facility. The Employee may request changes to the assigned Contract Dentist facility by contacting Customer Service Center at 800-589-4618. A list of Contract Dentists is available to all Enrollees at deltadentalins.com. The change must be requested prior to the 15th of the month to become effective on the first day of the following month.

We will provide you written notice of assignment to another Contract Dentist facility near the Enrollee's home if: 1) a requested facility is closed to further enrollment; 2) a chosen Contract Dentist facility withdraws from the plan; or 3) an assigned facility requests, for good cause, that the Enrollee be re-assigned to another facility.

All Treatment in Progress must be completed before you change to another Contract Dentist facility. For example, this would include: 1) partial or full dentures for which final impressions have been taken; 2) completion of root canals in progress; and 3) delivery of crowns when teeth have been prepared.

All services which are Benefits shall be rendered at the Contract Dentist facility assigned to the Enrollee. Delta Dental shall have no obligation or liability with respect to services rendered by Out-of Network Dentists, with the exception of Emergency Services or Specialist Services referred by a Contract Dentist, and authorized by Delta Dental. All authorized Specialist Services claims will be paid by Delta Dental less any applicable Copayments. A Contract Dentist may provide services either personally, or through associated Dentists, or the other technicians or hygienists who may lawfully perform the services.

If your assigned Contract Dentist facility terminates participation in the plan, that Contract Dentist facility will complete all Treatment in Progress as described above. If for any reason the Contract Dentist is unable to complete treatment, Delta Dental shall make reasonable and appropriate provisions for the completion of such treatment by another Contract Dentist.

Delta Dental shall give written notice to the Enrollee within a reasonable time of any termination or breach of contract, or inability to perform by any Contract Dentist if the Enrollee will be materially or adversely affected.

Continuity of Care

If you are a current Enrollee, you may have the right to obtain completion of care under this Contract with your terminated Contract Dentist for certain specified dental conditions. If you are a new Enrollee, you may have the right to completion of care under this Contract with your Out-of-Network Dentist for certain specified dental conditions. You must make a specific request for this completion of care benefit. To make a request, contact our Customer Service Center at 800-589-4618. You may also contact us to request a copy of Delta Dental's Continuity of Care Policy. Delta Dental is not required to continue care with the Dentist if you are not eligible under this Contract or if Delta Dental cannot reach agreement with the Out-of-Network Dentist or the terminated Contract Dentist on the terms regarding Enrollee care in accordance with California law.

Emergency Services

The assigned Contract Dentist facility maintains a 24 hour Emergency Services system seven (7) days a week. If Emergency Services are needed, you should contact the Contract Dentist facility whenever possible. If you are unable to reach the Contract Dentist facility for Emergency Services, you should call the Customer Service Center at 800-589-4618 for assistance in obtaining urgent care. During non-business hours or if you require Emergency Services and are 35 miles or more from your assigned Contract Dentist facility, you do not need to call for referral and may seek treatment from a Dentist other than at the assigned Contract Dentist facility. You are responsible for the Copayment(s) for any treatment received due to an emergency. Emergency dental care is limited to necessary care to stabilize your condition and/or provide palliative relief when you:

1) have made a Reasonable attempt to contact the Contract Dentist and the Contract Dentist is unavailable or you cannot be seen within 24 hours of making contact; or

2) have made a Reasonable attempt to contact Delta Dental prior to receiving Emergency Services, or it is Reasonable for you to access Emergency Services without prior contact with Delta Dental; or

3) reasonably believe that your condition makes it dentally/medically inappropriate to travel to the Contract Dentist to receive Emergency Services.

Further treatment must be obtained from the assigned Contract Dentist facility.

Specialist Services

Specialist Services for oral surgery, endodontics, periodontics or pediatric dentistry must be: 1) referred by the assigned Contract Dentist; and 2) authorized by us. You pay the specified Copayment. (Refer to the Schedules attached to this EOC.)

If you require Specialist Services and there is no Contract Specialist to provide these services within 35 miles of your home address, the assigned Contract Dentist must receive Authorization from Delta Dental to refer you to an Out-of-Network specialist to provide the Specialist Services. Specialist Services performed by an Out-of-Network specialist that are not authorized by Delta Dental will not be covered.

If the services of a Contract Orthodontist are needed, please refer to the Schedules attached to this EOC to determine Benefits.

Claims for Reimbursement

Claims for covered Emergency Services or authorized Specialist Services should be sent to us within 90 days of the end of treatment. Valid claims received after the 90-day period will be reviewed if you can show that it was not reasonably possible to submit the claim within that time. The address for claims submission is Claims Department, P.O. Box 1810, Alpharetta, GA 30023.

Provider Compensation

A Contract Dentist is compensated by Delta Dental through monthly capitation (an amount based on the number of Enrollees assigned to the Dentist), and by Enrollees through required Copayments for treatment received. A Contract Specialist is compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Copayment paid by the Enrollee. In no event does Delta Dental pay a Contract Dentist or a specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

You may obtain further information concerning compensation by calling Delta Dental at the toll-free telephone number shown in this booklet.

Processing Policies

The dental care guidelines for the DeltaCare USA plan explain to Contract Dentists what services are covered under the dental Contract. Contract Dentists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist that fall under the scope of Benefits of the dental plan are provided subject to any Copayments. If a Contract Dentist believes that an Enrollee should seek treatment from a specialist, the Contract Dentist contacts Delta Dental for a determination of whether the proposed treatment is a covered benefit. Delta Dental will also determine whether the proposed treatment requires treatment by a specialist. An Enrollee may contact Delta Dental's Customer Service department at 800-589-4618 for information regarding the dental care guidelines for DeltaCare USA.

Second Opinions

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your Contract Dentist. Delta Dental may also request that you obtain a second opinion to verify the necessity and appropriateness of dental treatment or the application of Benefits.

Second opinions will be rendered by a licensed Dentist in a timely manner, appropriate to the nature of your condition. Requests involving cases of imminent and serious health threat will be expedited (authorization approved or denied within 72 hours of receipt of the request, whenever possible). For assistance or additional information regarding the procedures and timeframes for second opinion authorizations, contact Delta Dental's Customer Service department at 800-589-4618 or write to Delta Dental.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Delta Dental. Delta Dental will authorize a second opinion by an Out-of-Network provider if an appropriately qualified Contract Dentist is not available. Delta Dental will only pay for a second opinion which Delta Dental has approved or authorized. You will be sent a written notification should Delta Dental decide not to authorize a second opinion. If you disagree with this determination, you may file a grievance with the plan or with the Department of Managed Health Care. Refer to the Enrollee Complaint Procedure section for more information.

Special Needs

If you believe you have a Special Health Care Need, you should contact our Customer Service department at 800-589-4618. We will confirm whether such a Special Health Care Need exists and what arrangements can be made to assist you in obtaining Benefits. We will not be responsible for the failure of any Dentist to comply with any law or regulation concerning treatment of persons with Special Health Care Needs which is applicable to the Dentist.

Facility Accessibility

Many facilities provide Delta Dental with information about special features of their offices, including accessibility information for patients with mobility impairments. To obtain information regarding facility accessibility, contact Delta Dental's Customer Service department at 800-589-4618.

ENROLLEE COMPLAINT PROCEDURE

Delta Dental or the Administrator shall provide notification if any dental services or claims are denied, in whole or in part, stating the specific reason or reasons for the denial. If you have any complaint regarding the denial of dental services or claims, the policies, procedures or operations of Delta Dental or the Administrator or the quality of dental services performed by a Contract Dentist, you may call the Customer Service Center at 800-589-4618, or the complaint may be addressed in writing to:

Quality Management Department
P.O. Box 6050
Artesia, CA 90702

Written communication must include: 1) the name of the patient; 2) the name, address, telephone number and ID number of the Pediatric Enrollee; and 3) the Dentist's name and facility location.

"Grievance" means a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by Pediatric Enrollee or the Enrollee's representative. Where the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

"Complaint" is the same as "grievance."

"Complainant" is the same as "grievant" and means the person who filed the grievance including the Enrollee, a representative designated by the Enrollee, or other individual with authority to act on behalf of the Enrollee.

Within 5 calendar days of the receipt of any complaint, the quality management coordinator will forward to you an acknowledgment of receipt of the complaint. Certain complaints may require that you be referred to a Dentist for clinical evaluation of the dental services provided. We will forward to you a determination, in writing, within 30 days of receipt of a complaint or shall provide a written explanation if additional time is required to report on the complaint. If the complaint involves severe pain and/or imminent and serious threat to a patient's dental health, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the grievance within three days.

If you have completed Delta Dental's grievance process, or you have been involved in Delta Dental's grievance procedure for more than 30 days, you may file a complaint with the California Department of Managed Health Care ("Department"). You may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to the Enrollee's health.

The Department is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone us, your plan, at **1-800-589-4618** and use our grievance process above before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may also be eligible for an Independent Medical Review ("IMR"). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet Website **(http://www.hmohelp.ca.gov)** has complaint forms, IMR application forms and instructions online.

The MPI is responsible for administering and resolving any enrollee complaints, grievances and appeals that concern enrollment, premium collection and/or termination relating to this dental plan. Please see the MPI's Evidence of Coverage for details.

If the group health plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), you may contact the U.S. Department of Labor, Employee Benefits Security Administration (EBSA) for further review of the claim or if you have questions about the rights under ERISA. You may also bring a civil action under section 502(a) of ERISA. The address of the U.S. Department of Labor is: U.S. Department of Labor, Employee Benefits Security Administration, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

Complaints Involving an Adverse Benefit Determination

For complaints involving an adverse benefit determination (e.g. a denial, modification or termination of a requested benefit or claim) the Enrollee must file a request for review (a complaint) with Delta Dental] within at least 180 days after receipt of the adverse determination. Our review will take into account all information, regardless of whether such information was submitted or considered initially. The review shall be conducted by a person who is neither the individual who made the original benefit determination, nor the subordinate of such individual. Upon request and free of charge, we will provide the Enrollee with copies of any pertinent documents that are relevant to the benefit determination, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in making the benefit determination. If the review of a denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the Contract, Delta Dental shall consult with a Dentist who has appropriate training and experience. If any consulting Dentist is involved in the review, the identity of such consulting Dentist will be available upon request.

GENERAL PROVISIONS

Public Policy Participation by Enrollees

Delta Dental's Board of Directors includes Enrollees who participate in establishing Delta Dental's public policy regarding Enrollees through periodic review of Delta Dental's Quality Assessment program reports and communications from Enrollees. Enrollees may submit any suggestions regarding Delta Dental's public policy in writing to:

Delta Dental of California
Customer Service Center
P.O. Box 997330
Sacramento, CA 95899-7330

Severability

If any part of the Contract, this EOC, Attachments or an amendment to any of these documents is found by a court or other authority to be illegal, void or not enforceable, all other portions of these documents will remain in full force and effect.

Misstatements on Application; Effect

In the absence of fraud or intentional misrepresentation of material fact in applying for or procuring coverage under the Contract and/or this EOC, all statements made by you will be deemed representations and not warranties. No such statement will be used in defense to a claim, unless it is contained in a written application.

Legal Actions

No action at law or in equity will be brought to recover on the Contract prior to expiration of 60 days after proof of loss has been filed in accordance with requirements of the Contract and/or this EOC, nor will an action be brought at all unless brought within three (3) years from expiration of the time within which proof of loss is required.

Conformity with Applicable Laws

All legal questions about the Contract and/or this EOC will be governed by the state of California where the Contract was entered into and is to be performed. Any part of the Contract and/or this EOC that conflicts with the laws of California, specifically Chapter 2.2 of Division 2 of the California Health and Safety Code and Chapter 1 of Division 1, of Title 28 of the California Code of Regulations, or federal law is hereby amended to conform to the minimum requirements of such laws. Any provision required to be in this Contract by either of the above shall bind Delta Dental whether or not provided in this Contract.

Third Party Administrator ("TPA")

Delta Dental may use the services of a TPA, duly registered under applicable state law, to provide services under the Contract. Any TPA providing such services or receiving such information shall enter into a separate Business Associate Agreement with Delta Dental providing that the TPA shall meet HIPAA and HITECH requirements for the preservation of protected health information of Enrollees.

Non-Discrimination

Delta Dental is committed to ensuring that no person is excluded from, or denied the benefits of our services, or otherwise discriminated against on the basis of race, color, national origin, disability, age, genetic testing, sexual orientation or gender identity. Any person who believes that he or she has individually, or as a member of any specific class of persons, been subjected to discrimination may file a complaint in writing to:

DeltaCare USA Customer Service
P.O. Box 1803
Alpharetta, GA 30023

Organ and Tissue Donation

Donating organ and tissue provides many societal benefits. Organ and tissue donation allows recipients of transplants to go on to lead fuller and more meaningful lives. Currently, the need for organ transplants far exceeds availability. If you are interested in organ donation, please speak to your physician. Organ donation begins at the hospital when a person is pronounced brain dead and identified as a potential organ donor. An organ procurement organization will become involved to coordinate the activities.

2017 Dental Standard Benefit Plan Design

Summary of Benefits and Coverage Member Cost Share amounts describe the Enrollee's out of pocket costs. Children's Dental Plan and Family Dental Plan designs apply to Individual Marketplace and Covered California for Small Business.		**Children's Dental Plan** **Copay Plan** **Pediatric Dental EHB** **Up to Age 19**
Actuarial Value		83.0%
		In-Network
Individual Deductible		None
Family Deductible (Two or more children)		Not applicable
Individual Out of Pocket Maximum		$350
Family Out of Pocket Maximum (Two or More Children)		$700
Office Copay		$0
Waiting Period (Waivered Condition provision, as defined in Health & Safety Code 1357.50 (a)(3)(J)(4) and Insurance Code 10198.6(d)		None
Annual Benefit Limit (the maximum amount the dental plan will pay in the benefit year)		None
Procedure Category	**Service Type**	**Member Cost Share**
Diagnostic & Preventive	Oral Exam	No charge
	Preventive - Cleaning	No charge
	Preventive - X-ray	No charge
	Sealants per Tooth	No charge
	Topical Fluoride Application	No charge
	Space Maintainers - Fixed	No charge
Basic Services	Restorative Procedures	See Benefits shown in *Schedule A* for 2017 Dental Copay Schedule
	Periodontal Maintenance Services	
Major Services	Periodontics (other than maintenance)	See Benefits shown in *Schedule A* for 2017 Dental Copay Schedule
	Endodontics	
	Crowns and Casts	
	Prosthodontics	
	Oral Surgery	
Orthodontia	Medically Necessary Orthodontia	$350

SCHEDULE A

Description of Benefits and Copayments
DeltaCare® USA
Children's Dental HMO
For Small Businesses

The Benefits shown below are performed as needed and deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the plan. **Please refer to *Schedule B* for further clarification of Benefits. Enrollees should discuss all treatment options with their Contract Dentist prior to services being rendered.**

Text that appears in italics below is specifically intended to clarify the delivery of Benefits under the DeltaCare® USA plan and is not to be interpreted as CDT-2016 procedure codes, descriptors or nomenclature which is under copyright by the American Dental Association. The American Dental Association may periodically change CDT codes or definitions. Such updated codes, descriptors and nomenclature may be used to describe these covered procedures in compliance with federal legislation.

Out-of-Pocket Maximum (OOPM) for Pediatric Enrollees

Pediatric Enrollee	**$350.00** each Accumulation Period
Multiple Pediatric Enrollees	**$700.00** each Accumulation Period

OOPM applies only to Essential Health Benefits (EHB) for Pediatric Enrollee(s). OOPM means the maximum amount of money that a Pediatric Enrollee must pay for Pediatric Benefits under this plan during an Accumulation Period. Payment for Premiums and payment for services that are Optional, that are upgraded treatments (such as precious or semi-precious metals and material upgrades) or that are not covered under the Contract will not count toward the OOPM and payment for such services will continue to apply even after the OOPM is met.

After a Pediatric Enrollee meets his or her OOPM, he or she will have no further payment for the remainder of the Accumulation Period for Pediatric Benefits. Once the amount paid by all Pediatric Enrollee(s) equals the OOPM for multiple Pediatric Enrollees, no further payment will be required by any of the Pediatric Enrollee(s) for the remainder of the Accumulation Period for Pediatric Benefits.

Delta Dental recommends that the Pediatric Enrollee or other party responsible for the Pediatric Enrollee keep a record of payment for Pediatric Benefits. If you have any questions regarding your OOPM, please contact the Customer Service department at 800-589-4618.

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D0100–D0999 I. DIAGNOSTIC			
D0999	Unspecified diagnostic procedure, by report	No charge	*Includes office visit, per visit (in addition to other services); In addition, shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D0120	Periodic oral evaluation -- established patient	No charge	*1 per 6 months per Contract Dentist*
D0140	Limited oral evaluation -- problem focused	No charge	*1 per Enrollee per Contract Dentist*
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	No charge	*1 per 6 months per Contract Dentist, included with D0120, D0150*
D0150	Comprehensive oral evaluation -- new or established patient	No charge	*Initial evaluation, 1 per Contract Dentist*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D0160	Detailed and extensive oral evaluation, problem focused, by report	No charge	*1 per Enrollee per Contract Dentist*
D0170	Re-evaluation - limited, problem focused (established patient; not post-operative visit)	No charge	*6 in 3 months, not to exceed 12 in a 12 month period*
D0180	Comprehensive periodontal evaluation - new or established patient	No charge	*Included with D0150*
D0210	Intraoral - complete series of radiographic images	No charge	*1 series every 36 months per Contract Dentist*
D0220	Intraoral - periapical first radiographic image	No charge	*20 images (D0220, D0230) in a 12 month period per Contract Dentist*
D0230	Intraoral - periapical each additional radiographic image	No charge	*20 images (D0220, D0230) in a 12 month period per Contract Dentist*
D0240	Intraoral - occlusal radiographic image	No charge	*2 in 6 months per Contract Dentist*
D0250	Extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	No charge	*1 per date of service*
D0270	Bitewing - single radiographic image	No charge	*1 (D0270, D0273) per date of service*
D0272	Bitewings - two radiographic images	No charge	*1 (D0272 D0273) in 6 months per Contract Dentist*
D0273	Bitewings - three radiographic images	No charge	*1 (D0270, D0273 per date of service); 1 (D0272, D0273) in 6 months per Contract Dentist*
D0274	Bitewings - four radiographic images	No charge	*1 (D0274, D0277) in 6 months per Contract Dentist*
D0277	Vertical bitewings - 7 to 8 radiographic images	No charge	*1 (D0274, D0277) in 6 months per Contract Dentist*
D0290	Posterior-anterior or lateral skull and facial bone survey radiographic image	No charge	*Limited to trauma or pathology; 3 per date of service*
D0310	Sialography	No charge	
D0320	Temporomandibular joint arthrogram, including injection	No charge	*Limited to trauma or pathology; 3 per date of service*
D0322	Tomographic survey	No charge	*2 in 12 months per Contract Dentist*
D0330	Panoramic radiographic image	No charge	*1 in 36 months per Contract Dentist*
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	No charge	*2 in 12 months per Contract Dentist*
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	No charge	*For the diagnosis and treatment of the specific clinical condition not apparent on radiographs; 4 per date of service*
D0460	Pulp vitalitytests	No charge	
D0470	Diagnostic casts	No charge	*For the evaluation of orthodontic benefits only; 1 per Contract Dentist unless special circumstances are documented (such as trauma or pathology which has affected the course of orthodontic treatment).*
D0502	Other oral pathology procedures, by report	No charge	*Performed by an oral pathologist*
D0601	Caries risk assessment and documentation, with a finding of low risk	No charge	*1 in 36 months per Contract Dentist or dental office; age 3 and above*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge	*1 in 36 months per Contract Dentist or dental office; age 3 and above*
D0603	Caries risk assessment and documentation, with a finding of high risk	No charge	*1 in 36 months per Contract Dentist or dental office; age 3 and above*
D1000-D1999 II. PREVENTIVE			
D1110	Prophylaxis - adult	No charge	*Cleaning; 1 (D1110, D1120) in 6 months*
D1120	Prophylaxis - child	No charge	*Cleaning; 1 (D1110, D1120) in 6 months*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D1206	Topical application of fluoride varnish	No charge	*1 (D1206, D1208) in 6 months*
D1208	Topical application of fluoride – excluding varnish	No charge	*1 (D1206, D1208) in 6 months*
D1310	Nutritional counseling for control of dental disease	No charge	
D1320	Tobacco counseling for the control and prevention of oral disease	No charge	
D1330	Oral hygiene instructions	No charge	
D1351	Sealant - per tooth	No charge	*1 per tooth in 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1352	Preventive resin restoration in a moderate to high caries risk patient – permanent tooth	No charge	*1 per tooth in 36 months per Contract Dentist; limited to permanent first and second molars without restorations or decay and third permanent molars that occupy the second molar position*
D1353	Sealant repair – per tooth	No charge	*The original dentist or dental office is responsible for any repair or replacement during the 24-month period after initial placement.*
D1510	Space maintainer - fixed - unilateral	No charge	*1 per quadrant; posterior teeth*
D1515	Space maintainer - fixed - bilateral	No charge	*1 per arch; posterior teeth*
D1520	Space maintainer - removable - unilateral	No charge	*1 per quadrant; posterior teeth*
D1525	Space maintainer - removable - bilateral	No charge	*1 per arch, through age 17; posterior teeth*
D1550	Re-cement or re-bond space maintainer	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1555	Removal of fixed space maintainer	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D2000-D2999 III. RESTORATIVE			
- Includes polishing, all adhesives and bonding agents, indirect pulp capping, bases, liners and acid etch procedures.			
- Replacement of crowns, inlays and onlays requires the existing restoration to be 5+ years (60+ months) old.			
D2140	Amalgam - one surface, primary or permanent	$25	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2150	Amalgam - two surfaces, primary or permanent	$30	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2160	Amalgam - three surfaces, primary or permanent	$40	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2161	Amalgam - four or more surfaces, primary or permanent	$45	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2330	Resin-based composite - one surface, anterior	$30	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2331	Resin-based composite - two surfaces, anterior	$45	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2332	Resin-based composite - three surfaces, anterior	$55	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2335	Resin-based composite - four or more surfaces or involving incisal angle (anterior)	$60	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D2390	Resin-based composite crown, anterior	$50	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2391	Resin-based composite - one surface, posterior	$30	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2392	Resin-based composite - two surfaces, posterior	$40	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2393	Resin-based composite - three surfaces, posterior	$50	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2394	Resin-based composite - four or more surfaces, posterior	$70	*1 in 12 months per Contract Dentist for primary teeth; 1 in 36 months per Contract Dentist for permanent teeth*
D2710	Crown - resin-based composite (indirect)	$140	*1 per 60 months, permanent teeth; age 13 through 18*
D2712	Crown - 3/4 resin-based composite (indirect)	$190	*1 per 60 months, permanent teeth; age 13 through 18*
D2721	Crown - resin with predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2740	Crown - porcelain/ceramic substrate	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2751	Crown - porcelain fused to predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2781	Crown - 3/4 cast predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2783	Crown - 3/4 porcelain/ceramic	$310	*1 per 60 months, permanent teeth; age 13 through 18*
D2791	Crown - full cast predominantly base metal	$300	*1 per 60 months, permanent teeth; age 13 through 18*
D2910	Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	$25	*1 in 12 months per Contract Dentist*
D2915	Re-cement or re-bond indirectly fabricated or prefabricated post and core	$25	
D2920	Re-cement or re-bond crown	$25	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$95	*1 in 12 months*
D2930	Prefabricated stainless steel crown - primary tooth	$65	*1 in 12 months*
D2931	Prefabricated stainless steel crown - permanent tooth	$75	*1 in 36 months*
D2932	Prefabricated resin crown	$75	*1 in 12 months for primary teeth; 1 in 36 months for permanent teeth*
D2933	Prefabricated stainless steel crown with resin window	$80	*1 in 12 month for primary teeth; 1 in 36 months for permanent teeth*
D2940	Protective restoration	$25	*1 in 6 months per Contract Dentist*
D2950	Core buildup, including any pins when required	$20	
D2951	Pin retention - per tooth, in addition to restoration	$25	*1 per tooth regardless of the number of pins placed; permanent teeth*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D2952	Post and core in addition to crown, indirectly fabricated	$100	*Base metal post; 1 per tooth; a benefit only in conjunction with covered crowns on root canal treated permanent teeth*
D2953	Each additional indirectly fabricated post - same tooth	$30	*Performed in conjunction with D2952*
D2954	Prefabricated post and core in addition to crown	$90	*1 per tooth; a benefit only in conjunction with covered crowns on root canal treated permanent teeth*
D2955	Post removal	$60	*Included in case fee by Contract Dentist or dental office who performed endodontic and restorative procedures. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist /dental office.*
D2957	Each additional prefabricated post - same tooth	$35	*Performed in conjunction with D2954*
D2971	Additional procedures to construct new crown under existing partial denture framework	$35	*Included in the fee for laboratory processed crowns. The listed fee applies for service provided by a Contract Dentist other than the original treating Dentist/dental office.*
D2980	Crown repair necessitated by restorative material failure	$50	*Repair during the 12 months following initial placement or previous repair is included, no additional charge to the Enrollee or plan is permitted by the original treating Contract Dentist /dental office.*
D2999	Unspecified restorative procedure, by report	$40	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D3000-D3999 IV. ENDODONTICS			
D3110	Pulp cap - direct (excluding final restoration)	$20	
D3120	Pulp cap - indirect (excluding final restoration)	$25	
D3220	Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	$40	*1 per primary tooth*
D3221	Pulpal debridement, primary and permanent teeth	$40	*1 per tooth*
D3222	Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	$60	*1 per permanent tooth*
D3230	Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	$55	*1 per tooth*
D3240	Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	$55	*1 per tooth*
D3310	Endodontic therapy, anterior tooth (excluding final restoration)	$195	*Root canal*
D3320	Endodontic therapy, bicuspid tooth (excluding final restoration)	$235	*Root canal*
D3330	Endodontic therapy, molar (excluding final restoration)	$300	*Root canal*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D3331	Treatment of root canal obstruction; non-surgical access	$50	
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	$195	
D3333	Internal root repair of perforation defects	$80	
D3346	Retreatment of previous root canal therapy - anterior	$240	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist /dental office.*
D3347	Retreatment of previous root canal therapy - bicuspid	$295	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist /dental office.*
D3348	Retreatment of previous root canal therapy - molar	$365	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or plan. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist /dental office.*
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	$85	*1 per permanent tooth*
D3352	Apexification/recalcification - interim medication replacement	$45	*1 per permanent tooth*
D3410	Apicoectomy - anterior	$240	*1 in 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3421	Apicoectomy - bicuspid (first root)	$250	*1 in 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3425	Apicoectomy - molar (first root)	$275	*1 in 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3426	Apicoectomy (each additional root)	$110	*1 in 24 months by the same Contract Dentist or dental office; permanent teeth only; a benefit for 3rd molar if it occupies the 1st or 2nd molar position or is an abutment for an existing fixed partial denture or removable partial denture with cast clasps or rests.*
D3430	Retrograde filling - per root	$90	
D3910	Surgical procedure for isolation of tooth with rubber dam	$30	
D3999	Unspecified endodontic procedure, by report	$100	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D4000-D4999 V. PERIODONTICS			
- Includes preoperative and postoperative evaluations and treatment under a local anesthetic.			
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$150	*1 per quadrant in 36 months, age 13+*
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per	$50	*1 per quadrant in 36 months, age 13+*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
	quadrant		
D4249	Clinical crown lengthening - hard tissue	$165	
D4260	Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	$265	*1 per quadrant in 36 months, age 13+*
D4261	Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	$140	*1 per quadrant in 36 months, age 13+*
D4265	Biologic materials to aid in soft and osseous tissue regeneration	$80	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$55	*1 per quadrant in 24 months; age 13+*
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30	*1 per quadrant in 24 months; age 13+*
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	$40	*1 treatment in any 12 consecutive months*
D4381	Localized delivery of antimicrobial agents via controlled release vehicle into diseased crevicular tissue, per tooth	$10	
D4910	Periodontal maintenance	$30	*1 per 3 months; service must be within the 24 months following the last scaling and root planing*
D4920	Unscheduled dressing change (by someone other than treating dentist or their staff)	$15	*1 per Contract Dentist; age 13+*
D4999	Unspecified periodontal procedure, by report	$350	*Enrollees age 13+. Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5000-D5899 VI. PROSTHODONTICS (removable)			
- For all listed dentures and partial dentures, Copayment includes after delivery adjustments and tissue conditioning, if needed, for the first six months after placement. The Enrollee must continue to be eligible, and the service must be provided at the Contract Dentist's facility where the denture was originally delivered.			
- Rebases, relines and tissue conditioning are limited to 1 per denture during any 12 consecutive months.			
- Replacement of a denture or a partial denture requires the existing denture to be 5+ years (60+ months) old.			
D5110	Complete denture - maxillary	$300	*1 per 60 months*
D5120	Complete denture - mandibular	$300	*1 per 60 months*
D5130	Immediate denture - maxillary	$300	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*
D5140	Immediate denture - mandibular	$300	*1 per lifetime; subsequent complete dentures (D5110, D5120) are not a Benefit within 60 months.*
D5211	Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	$300	*1 per 60 months*
D5212	Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	$300	*1 per 60 months*
D5213	Maxillary partial denture - cast metal	$335	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
	framework with resin denture bases (including any conventional clasps, rests and teeth)		
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	$335	*1 per 60 months*
D5410	Adjust complete denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 in 12 months per Contract Dentist after the initial 6 months*
D5411	Adjust complete denture - mandibular	$20	*1 per day of service per Contract Dentist; up to 2 in 12 months per Contract Dentist after the initial 6 months*
D5421	Adjust partial denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 in 12 months per Contract Dentist after the initial 6 months*
D5422	Adjust partial denture - mandibular	$20	*1 per day of service per Contract Dentist; up to 2 in 12 months per Contract Dentist after the initial 6 months*
D5510	Repair broken complete denture base	$40	*1 per day of service per Contract Dentist; up to 2 per arch in 12 months per Contract Dentist after the initial 6 months*
D5520	Replace missing or broken teeth - complete denture (each tooth)	$40	*Up to 4 per arch per date of service after the initial 6 months; up to 2 per arch in 12 months per Contract Dentist*
D5610	Repair resin denture base	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch in 12 months per Contract Dentist after the initial 6 months*
D5620	Repair cast framework	$40	*1 per day of service per Contract Dentist; up to 2 per arch in 12 months per Contract Dentist after the initial 6 months*
D5630	Repair or replace broken clasp - per tooth	$50	*3 per date of service after the initial 6 months; 2 per arch in 12 months per Contract Dentist*
D5640	Replace broken teeth - per tooth	$35	*4 per arch per date of service after the initial 6 months; 2 per arch in 12 months per Contract Dentist*
D5650	Add tooth to existing partial denture	$35	*Up to 3 per date of service per Contract Dentist; 1 per tooth after the initial 6 months*
D5660	Add clasp to existing partial denture - per tooth	$60	*3 per date of service after the initial 6 months; 2 per arch in 12 months per Contract Dentist*
D5730	Reline complete maxillary denture (chairside)	$60	*Included for the first 6 months after placement by the Contract Dentist or dental office where the appliance was originally delivered; 1 per 12 month period after the initial 6 months*
D5731	Reline complete mandibular denture (chairside)	$60	*1 per 12 month period after the initial 6 months*
D5740	Reline maxillary partial denture (chairside)	$60	*1 per 12 month period after the initial 6 months*
D5741	Reline mandibular partial denture (chairside)	$60	*1 per 12 month period after the initial 6 months*
D5750	Reline complete maxillary denture (laboratory)	$90	*1 per 12 month period after the initial 6 months*
D5751	Reline complete mandibular denture (laboratory)	$90	*1 per 12 month period after the initial 6 months*
D5760	Reline maxillary partial denture (laboratory)	$80	*1 per 12 month period after the initial 6 months*
D5761	Reline mandibular partial denture (laboratory)	$80	*1 per 12 month period after the initial 6 months*
D5850	Tissue conditioning, maxillary	$30	*2 per prosthesis in a 36-month period after the initial 6 months*
D5851	Tissue conditioning, mandibular	$30	*2 per prosthesis in a 36-month period after the initial 6 months*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D5862	Precision attachment, by report	$90	*Included in the fee for prosthetic and restorative procedures by the Contract Dentist or dental office where the service was originally delivered. The listed fee applies for service provided by a dentist other than the original treating Contract Dentist or dental office.*
D5863	Overdenture – complete maxillary	$300	*1 in 60 months*
D5865	Overdenture – complete mandibular	$300	*1 in 60 months*
D5899	Unspecified removable prosthodontic procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D5900-D5999 VII. MAXILLOFACIAL PROSTHETICS			
- All maxillofacial prosthetic procedures require prior authorization.			
D5911	Facial moulage (sectional)	$285	
D5912	Facial moulage (complete)	$350	
D5913	Nasal prosthesis	$350	
D5914	Auricular prosthesis	$350	
D5915	Orbital prosthesis	$350	
D5916	Ocular prosthesis	$350	
D5919	Facial prosthesis	$350	
D5922	Nasal septal prosthesis	$350	
D5923	Ocular prosthesis, interim	$350	
D5924	Cranial prosthesis	$350	
D5925	Facial augmentation implant prosthesis	$200	
D5926	Nasal prosthesis, replacement	$200	
D5927	Auricular prosthesis, replacement	$200	
D5928	Orbital prosthesis, replacement	$200	
D5929	Facial prosthesis, replacement	$200	
D5931	Obturator prosthesis, surgical	$350	
D5932	Obturator prosthesis, definitive	$350	
D5933	Obturator prosthesis, modification	$150	*2 in 12 months*
D5934	Mandibular resection prosthesis with guide flange	$350	
D5935	Mandibular resection prosthesis without guide flange	$350	
D5936	Obturator prosthesis, interim	$350	
D5937	Trismus appliance (not for TMD treatment)	$85	
D5951	Feeding aid	$135	
D5952	Speech aid prosthesis, pediatric	$350	
D5953	Speech aid prosthesis, adult	$350	
D5954	Palatal augmentation prosthesis	$135	
D5955	Palatal lift prosthesis, definitive	$350	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D5958	Palatal lift prosthesis, interim	$350	
D5959	Palatal lift prosthesis, modification	$145	*2 in 12 months*
D5960	Speech aid prosthesis, modification	$145	*2 in 12 months*
D5982	Surgical stent	$70	
D5983	Radiation carrier	$55	
D5984	Radiation shield	$85	
D5985	Radiation cone locator	$135	
D5986	Fluoride gel carrier	$35	
D5987	Commissure splint	$85	
D5988	Surgical splint	$95	
D5991	Vesiculobullous disease medicament carrier	$70	
D5999	Unspecified maxillofacial prosthesis, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the Enrollee has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D6000-D6199 VIII. IMPLANT SERVICES			
- A Benefit only under exceptional medical conditions, as defined in Schedule B. Prior authorization is required. Refer also to Schedule B.			
D6010	Surgical placement of implant body: endosteal implant	$350	*A Benefit only under exceptional medical conditions.*
D6040	Surgical placement: eposteal implant	$350	*A Benefit only under exceptional medical conditions.*
D6050	Surgical placement: transosteal implant	$350	*A Benefit only under exceptional medical conditions.*
D6055	Connecting bar – implant supported or abutment supported	$350	*A Benefit only under exceptional medical conditions.*
D6056	Prefabricated abutment – includes modification and placement	$135	*A Benefit only under exceptional medical conditions.*
D6057	Custom fabricated abutment – includes placement	$180	*A Benefit only under exceptional medical conditions.*
D6058	Abutment supported porcelain/ceramic crown	$320	*A Benefit only under exceptional medical conditions.*
D6059	Abutment supported porcelain fused to metal crown (high noble metal)	$315	*A Benefit only under exceptional medical conditions.*
D6060	Abutment supported porcelain fused to metal crown (predominantly base metal)	$295	*A Benefit only under exceptional medical conditions.*
D6061	Abutment supported porcelain fused to metal crown (noble metal)	$300	*A Benefit only under exceptional medical conditions.*
D6062	Abutment supported cast metal crown (high noble metal)	$315	*A Benefit only under exceptional medical conditions.*
D6063	Abutment supported cast metal crown (predominantly base metal)	$300	*A Benefit only under exceptional medical conditions.*
D6064	Abutment supported cast metal crown (noble metal)	$315	*A Benefit only under exceptional medical conditions.*
D6065	Implant supported porcelain/ceramic crown	$340	*A Benefit only under exceptional medical conditions.*
D6066	Implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble	$335	*A Benefit only under exceptional medical conditions.*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
	metal)		
D6067	Implant supported metal crown (titanium, titanium alloy, high noble metal)	$340	*A Benefit only under exceptional medical conditions.*
D6068	Abutment supported retainer for porcelain/ceramic FPD	$320	*A Benefit only under exceptional medical Conditions.*
D6069	Abutment supported retainer for porcelain fused to metal FPD (high noble metal)	$315	*A Benefit only under exceptional medical conditions.*
D6070	Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	$290	*A Benefit only under exceptional medical conditions.*
D6071	Abutment supported retainer for porcelain fused to metal FPD (noble metal)	$300	*A Benefit only under exceptional medical conditions.*
D6072	Abutment supported retainer for cast metal FPD (high noble metal)	$315	*A Benefit only under exceptional medical conditions.*
D6073	Abutment supported retainer for cast metal FPD (predominantly base metal)	$290	*A Benefit only under exceptional medical conditions.*
D6074	Abutment supported retainer for cast metal FPD (noble metal)	$320	*A Benefit only under exceptional medical conditions.*
D6075	Implant supported retainer for ceramic FPD	$335	*A Benefit only under exceptional medical conditions.*
D6076	Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	$330	*A Benefit only under exceptional medical conditions.*
D6077	Implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	$350	*A Benefit only under exceptional medical conditions.*
D6080	Implant maintenance procedures when prostheses are removed and reinserted, including cleansing of prostheses and abutments	$30	*A Benefit only under exceptional medical conditions.*
D6090	Repair implant supported prosthesis, by report	$65	*A Benefit only under exceptional medical conditions.*
D6091	Replacement of semi-precision or precision attachment (male or female component) of implant/abutment supported prosthesis, per attachment	$40	*A Benefit only under exceptional medical conditions.*
D6092	Re-cement or re-bond implant/abutment supported crown	$25	*A Benefit only under exceptional medical conditions.*
D6093	Re-cement or re-bond implant/abutment supported fixed partial denture	$35	*A Benefit only under exceptional medical conditions.*
D6094	Abutment supported crown - (titanium)	$295	*A Benefit only under exceptional medical conditions.*
D6095	Repair implant abutment, by report	$65	*A Benefit only under exceptional medical conditions.*
D6100	Implant removal, by report	$110	*A Benefit only under exceptional medical conditions.*
D6110	Implant /abutment supported removable denture for edentulous arch – maxillary	$350	*A Benefit only under exceptional medical conditions.*
D6111	Implant /abutment supported removable denture for edentulous arch – mandibular	$350	*A Benefit only under exceptional medical conditions.*
D6112	Implant /abutment supported removable denture for partially edentulous arch – maxillary	$350	*A Benefit only under exceptional medical conditions.*
D6113	Implant /abutment supported removable denture for partially edentulous arch – mandibular	$350	*A Benefit only under exceptional medical conditions.*
D6114	Implant /abutment supported fixed denture for	$350	*A Benefit only under exceptional medical*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
	edentulous arch – maxillary		*conditions.*
D6115	Implant /abutment supported fixed denture for edentulous arch – mandibular	$350	*A Benefit only under exceptional medical conditions.*
D6116	Implant /abutment supported fixed denture for partially edentulous arch – maxillary	$350	*A Benefit only under exceptional medical conditions.*
D6117	Implant /abutment supported fixed denture for partially edentulous arch – mandibular	$350	*A Benefit only under exceptional medical conditions.*
D6190	Radiographic/surgical implant index, by report	$75	*A Benefit only under exceptional medical conditions.*
D6194	Abutment supported retainer crown for FPD (titanium)	$265	*A Benefit only under exceptional medical conditions.*
D6199	Unspecified implant procedure, by report	$350	*Implant services are a benefit only when exceptional medical conditions are documented and shall be reviewed for medical necessity. Written documentation shall describe the specific conditions addressed by the procedure, the rationale demonstrating the medical necessity, any pertinent history and the proposed treatment.*
D6200-D6999 IX. PROSTHODONTICS, fixed			
- Each retainer and each pontic constitutes a unit in a fixed partial denture (bridge)			
- Replacement of a crown, pontic, inlay, onlay or stress breaker requires the existing bridge to be 5+ years (60+ months) old.			
D6211	Pontic - cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6241	Pontic - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6245	Pontic - porcelain /ceramic	$300	*1 per 60 months; age 13+*
D6251	Pontic – resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6721	Retainer crown – resin with predominantly base metal	$300	*1 per 60 months; age 13+*
D6740	Retainer crown - porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6751	Retainer crown - porcelain fused to predominantly base metal	$300	*1 per 60 months; age 13+*
D6781	Retainer crown - 3/4 cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6783	Retainer crown - 3/4 porcelain/ceramic	$300	*1 per 60 months; age 13+*
D6791	Retainer crown - full cast predominantly base metal	$300	*1 per 60 months; age 13+*
D6930	Re-cement or re-bond fixed partial denture	$40	*Recementation during the 12 months after initial placement is included; no additional charge to the Enrollee or plan is permitted. The listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist /dental office.*
D6980	Fixed partial denture repair necessitated by restorative material failure	$95	
D6999	Unspecified fixed prosthodontic procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment. Not a benefit within 12 months of initial placement of a*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
			fixed partial denture by the same Contract Dentist/office.
D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY			
- Prior authorization required for procedures performed by a Contract Specialist. Medical necessity must be demonstrated for procedures D7340 - D7997. Refer also to Schedule B.			
- Includes preoperative and postoperative evaluations and treatment under a local anesthetic. Postoperative services include exams, suture removal and treatment of complications.			
D7111	Extraction, coronal remnants - deciduous tooth	$40	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65	
D7210	Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	$120	
D7220	Removal of impacted tooth - soft tissue	$95	
D7230	Removal of impacted tooth - partially bony	$145	
D7240	Removal of impacted tooth - completely bony	$160	
D7241	Removal of impacted tooth - completely bony, with unusual surgical complications	$175	
D7250	Surgical removal of residual tooth roots (cutting procedure)	$80	
D7260	Oroantral fistula closure	$280	
D7261	Primary closure of a sinus perforation	$285	
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	$185	*1 per arch regardless of number of teeth involved; permanent anterior teeth*
D7280	Surgical access of an unerupted tooth	$220	
D7283	Placement of device to facilitate eruption of impacted tooth	$85	*For active orthodontic treatment only*
D7285	Incisional biopsy of oral tissue - hard (bone, tooth)	$180	*1 per arch per date of service; regardless of number of areas involved*
D7286	Incisional biopsy of oral tissue - soft	$110	*3 per date of service*
D7290	Surgical repositioning of teeth	$185	*1 per arch, for permanent teeth only; applies to active orthodontic treatment*
D7291	Transseptal fiberotomy/supra crestal fiberotomy, by report	$80	*1 per arch; applies to active orthodontic treatment*
D7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$85	
D7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$50	
D7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	$120	
D7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	$65	
D7340	Vestibuloplasty - ridge extension (secondary epithelialization)	$350	*1 per arch per 60 months*
D7350	Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and	$350	*1 per arch*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
	hyperplastic tissue)		
D7410	Excision of benign lesion up to 1.25 cm	$75	
D7411	Excision of benign lesion greater than 1.25 cm	$115	
D7412	Excision of benign lesion, complicated	$175	
D7413	Excision of malignant lesion up to 1.25 cm	$95	
D7414	Excision of malignant lesion greater than 1.25 cm	$120	
D7415	Excision of malignant lesion, complicated	$255	
D7440	Excision of malignant tumor - lesion diameter up to 1.25 cm	$105	
D7441	Excision of malignant tumor - lesion diameter greater than 1.25 cm	$185	
D7450	Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm	$180	
D7451	Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$330	
D7460	Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm	$155	
D7461	Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm	$250	
D7465	Destruction of lesion(s) by physical or chemical method, by report	$40	
D7471	Removal of lateral exostosis (maxilla or mandible)	$140	*1 per quadrant*
D7472	Removal of torus palatinus	$145	*1 per lifetime*
D7473	Removal of torus mandibularis	$140	*1 per quadrant*
D7485	Surgical reduction of osseous tuberosity	$105	*1 per quadrant*
D7490	Radical resection of maxilla or mandible	$350	
D7510	Incision and drainage of abscess - intraoral soft tissue	$70	*1 per quadrant per date of service*
D7511	Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$70	*1 per quadrant per date of service*
D7520	Incision and drainage of abscess - extraoral soft tissue	$70	
D7521	Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	$80	
D7530	Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue	$45	*1 per date of service*
D7540	Removal of reaction producing foreign bodies, musculoskeletal system	$75	*1 per date of service*
D7550	Partial ostectomy/sequestrectomy for removal of non-vital bone	$125	*1 per quadrant per date of service*
D7560	Maxillary sinusotomy for removal of tooth fragment or foreign body	$235	
D7610	Maxilla - open reduction (teeth immobilized, if present)	$140	
D7620	Maxilla - closed reduction (teeth immobilized, if present)	$250	
D7630	Mandible - open reduction (teeth immobilized, if present)	$350	
D7640	Mandible - closed reduction (teeth	$350	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
	immobilized, if present)		
D7650	Malar and/or zygomatic arch - open reduction	$350	
D7660	Malar and/or zygomatic arch - closed reduction	$350	
D7670	Alveolus - closed reduction may include stabilization of teeth	$170	
D7671	Alveolus - open reduction may include stabilization of teeth	$230	
D7680	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350	
D7710	Maxilla - open reduction	$110	
D7720	Maxilla - closed reduction	$180	
D7730	Mandible - open reduction	$350	
D7740	Mandible - closed reduction	$290	
D7750	Malar and/or zygomatic arch - open reduction	$220	
D7760	Malar and/or zygomatic arch - closed reduction	$350	
D7770	Alveolus - open reduction stabilization of teeth	$135	
D7771	Alveolus, closed reduction stabilization of teeth	$160	
D7780	Facial bones - complicated reduction with fixation and multiple surgical approaches	$350	
D7810	Open reduction of dislocation	$350	
D7820	Closed reduction of dislocation	$80	
D7830	Manipulation under anesthesia	$85	
D7840	Condylectomy	$350	
D7850	Surgical discectomy, with/without implant	$350	
D7852	Disc repair	$350	
D7854	Synovectomy	$350	
D7856	Myotomy	$350	
D7858	Joint reconstruction	$350	
D7860	Arthrotomy	$350	
D7865	Arthroplasty	$350	
D7870	Arthrocentesis	$90	
D7871	Non-arthroscopic lysis and lavage	$150	
D7872	Arthroscopy - diagnosis, with or without biopsy	$350	
D7873	Arthroscopy - surgical: lavage and lysis of adhesions	$350	
D7874	Arthroscopy - surgical: disc repositioning and stabilization	$350	
D7875	Arthroscopy - surgical: synovectomy	$350	
D7876	Arthroscopy - surgical: discectomy	$350	
D7877	Arthroscopy - surgical: debridement	$350	
D7880	Occlusal orthotic device, by report	$120	
D7899	Unspecified TMD therapy, by report	$350	
D7910	Suture of recent small wounds up to 5 cm	$35	
D7911	Complicated suture - up to 5 cm	$55	
D7912	Complicated suture - greater than 5 cm	$130	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D7920	Skin graft (identify defect covered, location and type of graft)	$120	
D7940	Osteoplasty - for orthognathic deformities	$160	
D7941	Osteotomy - mandibular rami	$350	
D7943	Osteotomy - mandibular rami with bone graft; includes obtaining the graft	$350	
D7944	Osteotomy - segmented or subapical	$275	
D7945	Osteotomy - body of mandible	$350	
D7946	Lefort I (maxilla - total)	$350	
D7947	Lefort I (maxilla - segmented)	$350	
D7948	Lefort II or lefort III (osteoplasty of facial bones for midface hypoplasia or retrusion) - without bone graft	$350	
D7949	Lefort II or lefort III - with bone graft	$350	
D7950	Osseous, osteoperiosteal, or cartilage graft of the mandible or maxilla - autogenous or nonautogenous, by report	$190	
D7951	Sinus augmentation with bone or bone substitutes via a lateral open approach	$290	
D7952	Sinus augmentation via a vertical approach	$175	
D7955	Repair of maxillofacial soft and/or hard tissue defect	$200	
D7960	Frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	$120	*1 per arch per date of service; a benefit only when the permanent incisors and cuspids have erupted*
D7963	Frenuloplasty	$120	*1 per arch per date of service; a benefit only when the permanent incisors and cuspids have erupted*
D7970	Excision of hyperplastic tissue - per arch	$175	*1 per arch per date of service*
D7971	Excision of pericoronal gingiva	$80	
D7972	Surgical reduction of fibrous tuberosity	$100	*1 per quadrant per date of service*
D7980	Sialolithotomy	$155	
D7981	Excision of salivary gland, by report	$120	
D7982	Sialodochoplasty	$215	
D7983	Closure of salivary fistula	$140	
D7990	Emergency tracheotomy	$350	
D7991	Coronoidectomy	$345	
D7995	Synthetic graft - mandible or facial bones, by report	$150	
D7997	Appliance removal (not by dentist who placed appliance), includes removal of archbar	$60	*Removal of appliances related to surgical procedures only; 1 per arch per date of service; the listed fee applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D7999	Unspecified oral surgery procedure, by report	$350	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
			pertinent history and the actual treatment.
D8000-D8999 XI. ORTHODONTICS - Medically Necessary			
- Orthodontic Services must meet medical necessity as determined by a Contract Dentist. Orthodontic treatment is a benefit only when medically necessary as evidenced by a severe handicapping malocclusion and when a prior authorization is obtained. Severe handicapping malocclusion is not a cosmetic condition. Teeth must be severely misaligned causing functional problems that compromise oral and/or general health. *- Pediatric Enrollee must continue to be eligible, benefits for medically necessary orthodontics will be provided in periodic payments to the Contract Dentist.* *- Comprehensive orthodontic treatment procedure (D8080) includes all appliances, adjustments, insertion, removal and post treatment stabilization (retention). The Enrollee must continue to be eligible during active treatment. No additional charge to the Enrollee is permitted from the original treating Contract Orthodontist or dental office who received the comprehensive case fee. A separate fee applies for services provided by a Contract Orthodontist other than the original treating Contract Orthodontist or dental office.* *- Refer to Schedule B for additional information on Medically Necessary Orthodontics.*			
- Cost Share for Medically Necessary orthodontics applies to course of treatment, not individual benefit years within a multi-year course of treatment. This Cost Share applies to the course of treatment as long as the Pediatric Enrollee remains enrolled in the Program.			
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$350	*1 per Enrollee per phase of treatment*
D8210	Removable appliance therapy		*1 per lifetime; age 6 through 12*
D8220	Fixed appliance therapy		*1 per lifetime; age 6 through 12*
D8660	Pre-orthodontic treatment examination to monitor growth and development		*1 per 3 months when performed by the same Contract Dentist or dental office; up to 6 visits per lifetime*
D8670	Periodic orthodontic treatment visit		*1 per 3 months; included in comprehensive case fee*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))		*1 per arch for each authorized phase of orthodontic treatment; included in comprehensive case fee.*
D8691	Repair of orthodontic appliance		*1 per appliance; included in comprehensive case fee.*
D8692	Replacement of lost or broken retainer		*1 per arch; within 24 months following the date of service for orthodontic retention (D8680)*
D8693	Re-cement or re-bond fixed retainer		*1 per Contract Dentist; included in comprehensive case fee.*
D8999	Unspecified orthodontic procedure, by report		*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*
D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES			
D9110	Palliative (emergency) treatment of dental pain - minor procedure	$30	*1 per date of service per Contract Dentist; regardless of the number of teeth and/or areas treated*
D9120	Fixed partial denture sectioning	$95	
D9210	Local anesthesia not in conjunction with operative or surgical procedures	$10	*1 per date of service per Contract Dentist; for use to perform a differential diagnosis or as a therapeutic injection to eliminate or control a disease or abnormal state*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D9211	Regional block anesthesia	$20	
D9212	Trigeminal division block anesthesia	$60	
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15	
D9223	Deep sedation/general anesthesia - each 15 minute increment	$45	*Covered only when given by a Contract Dentist for covered oral surgery*
D9230	Inhalation of nitrous oxide / anxiolysis, analgesia	$15	*(Where available)*
D9241	Intravenous moderate (conscious) sedation/analgesia – first 30 minutes	See D9243	*Refer to D9243 for copayment and billing*
D9242	ravenous moderate (conscious) sedation/analgesia – each additional 15 minutes	See D9243	*Refer to D9243 for copayment and billing*
D9243	Intravenous moderate (conscious) sedation/analgesia – each 15 minute increment	$60	*Covered only when given by a Contract Dentist for covered oral surgery*
D9248	Non-intravenous conscious sedation	$65	*Where available; 1 per date of service per Contract Dentist*
D9310	Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	$50	
D9410	House/extended care facility call	$50	*1 per Enrollee per date of service*
D9420	Hospital or ambulatory surgical center call	$135	
D9430	Office visit for observation (during regularly scheduled hours) - no other services performed	$20	*1 per date of service per Contract Dentist*
D9440	Office visit - after regularly scheduled hours	$45	*1 per date of service per Contract Dentist*
D9610	Therapeutic parenteral drug, single administration	$30	*4 of (D9610, D9612) injections per date of service*
D9612	Therapeutic parenteral drugs, two or more administrations, different medications	$40	*4 of (D9610, D9612) injections per date of service*
D9910	Application of desensitizing medicament	$20	*1 in 12 months per Contract Dentist; permanent teeth*
D9930	Treatment of complications (post-surgical) - unusual circumstances, by report	$35	*1 per date of service per Contract Dentist within 30 days of an extraction*
D9950	Occlusion analysis - mounted case	$120	*Prior authorization is required; 1 in 12 months for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9951	Occlusal adjustment - limited	$45	*1 in 12 months for quadrant per Contract Dentist; age 13+*
D9952	Occlusal adjustment - complete	$210	*1 in 12 months following occlusion analysis - mounted case (D9950) for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9999	Unspecified adjunctive procedure, by report	No charge	*Shall be used: for a procedure which is not adequately described by a CDT code; or for a procedure that has a CDT code that is not a benefit but the patient has an exceptional medical condition to justify the medical necessity. Documentation shall include the specific conditions addressed by the procedure, the rationale demonstrating medical necessity, any pertinent history and the actual treatment.*

Endnotes:
Base metal is the Benefit. If noble or high noble metal (precious) is used for a crown, bridge, indirectly fabricated post and core, inlay or onlay, the Enrollee will be charged the additional laboratory cost of the noble or high noble metal. If covered, an additional laboratory charge also applies to a titanium crown.

Porcelain/ceramic crown, pontic and fixed bridge retainer on molars is considered a material upgrade with a maximum additional charge to the Enrollee of $150 per unit.

Name brand, laboratory processed or in-office processed crowns/pontics produced through specialized technique or materials are material upgrades. The Contract Dentist may charge an additional fee not to exceed $325 in addition to the listed Copayment. Refer to *Schedule B, Limitations and Exclusions of Benefits* for additional information.

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Copayment. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by the plan. The Enrollee pays the Copayment specified for such services.

Procedures not listed above are not covered, however, may be available at the Contract Dentist's "filed fees."

"Filed fees" mean the Contract Dentist's fees on file with the plan. Questions regarding these fees should be directed to the Customer Service department at 800-589-4618.

Optional or upgraded procedure(s) are defined as any alternative procedure(s) presented by the DeltaCare USA Dentist and formally agreed upon by financial consent that satisfies the same dental need as a covered procedure. Enrollee may elect an Optional or upgraded procedure, subject to the limitations and exclusions of the plan. The applicable charge to the Enrollee is the difference between the DeltaCare USA Dentist's regularly charged fee (or contracted fee, when applicable) for the Optional or upgraded procedure and the covered procedure, plus any applicable Copayment for the covered procedure.

Additional Endnotes to Covered California's 2017 Dental Standard Benefit Plan Designs
Pediatric Dental EHB Notes (only applicable to the pediatric portion of the Children's Dental Plan, Family Dental Plan or Group Dental Plan)

1) In a coinsurance plan, each child is responsible for the individual deductible unless the family deductible has been met. Once a child's individual deductible or the family deductible is reached, cost sharing applies until the child's out-of- pocket maximum is reached. *(Not applicable to Children's Dental HMO.)*
2) Deductible is waived for Diagnostic and Preventive Services. *(Not applicable to Children's Dental HMO.)*
3) Cost sharing payments made by each individual child for in-network covered services accrue to the child's out-of- pocket maximum. Once the child's individual out-of-pocket maximum has been reached, the plan pays all costs for covered services for that child.
4) In a plan with two or more children, cost sharing payments made by each individual child for in-network services contribute to the family in-network deductible, if applicable, as well as the family out-of-pocket maximum.
5) In a plan with two or more children, cost sharing payments made by each individual child for out-of-network covered services contribute to the family out-of-network deductible, if applicable, and do not accumulate to the family out-of- pocket maximum. *(Not applicable to Children's Dental HMO.)*
6) Administration of these plan designs must comply with requirements of the pediatric dental EHB benchmark plan, including coverage of services in circumstances of medical necessity as defined in the Early Periodic Screening, Diagnosis and Treatment (EPSDT) benefit.
7) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.
8) Member cost share for Medically Necessary Orthodontia services applies to course of treatment, not individual benefit years within a multi-year course of treatment. This member cost share applies to the course of treatment as long as the member remains enrolled in the plan.

Adult Dental Benefit Notes (only applicable to the Family Dental Plan and Group Dental Plan)

9) Each adult is responsible for an individual deductible. (*Not applicable to Family Dental HMO.)*

10) Deductible is waived for Diagnostic and Preventive Services. *(Not applicable to Family Dental HMO.)*

11) The requirements set forth in 10 CCR 6522 (a)(4)(A) and (a)(5)(A) shall apply to the Group Dental Plan design.

12) Tooth whitening, adult orthodontia and implants are not covered services.

SCHEDULE B

Limitations and Exclusions of Benefits
DeltaCare® USA
Children's Dental HMO
For Small Businesses

Limitations of Benefits for Pediatric Enrollees

1. The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Copayments. Additional requests, beyond the stated frequency limitations, for prophylaxis and fluoride procedures (D1110, D1120, D1206 and D1208) shall be considered for prior authorization when documented medical necessity is justified due to a physical limitation and/or an oral condition that prevents daily oral hygiene.*
2. A filling is a Benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
3. A crown is a Benefit when there is insufficient tooth structure to support a filling or to replace an existing crown that is non-functional or non-restorable and meets the five+ year (60+ months) limitation.
4. If a porcelain margin is also chosen by the Enrollee for a covered porcelain-fused-to-metal crown, the maximum additional cost for this laboratory upgrade is $75.00.
5. The replacement of an existing inlay, onlay, crown, fixed partial denture (bridge) or a removable full or partial denture is covered when:
   a. The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, **and**
   b. Either of the following:
      - The existing non-functional restoration/bridge/denture was placed five or more years (60+ months) prior to its replacement, **or**
      - If an existing partial denture is less than five years old (60 months), but must be replaced by a new partial denture due to the loss of a natural tooth, which cannot be replaced by adding another tooth to the existing partial denture.
6. Coverage for the placement of a fixed partial denture (bridge) or removable partial denture:
   a. Fixed partial denture (bridge):
      - A fixed partial denture is a Benefit only when medical conditions or employment preclude the use of a removable partial denture.
      - The sole tooth to be replaced in the arch is an anterior tooth, and the abutment teeth are not periodontally involved, **or**
      - The new bridge would replace an existing, non-functional bridge utilizing identical abutments and pontics, **or**
      - Each abutment tooth to be crowned meets Limitation #3.
   b. Removable partial denture:
      - Cast metal (D5213, D5214), one or more teeth are missing in an arch.
      - Resin based (D5211, D5212), one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease.
7. Interim partial dentures (stayplates), in conjunction with fixed or removable appliances, are limited to the replacement of extracted anterior teeth for adults during a healing period when the teeth cannot be added to an existing partial denture.
8. Excision of the frenum is a Benefit only when it results in limited mobility of the tongue, it causes a large diastema between teeth or it interferes with a prosthetic appliance.

9. Benefits for a soft tissue management program are limited to those parts, which are listed covered services listed on Schedule A. If an Enrollee declines non-covered services within a soft tissue management program, it does not eliminate or alter other covered Benefits.
10. A new removable partial or complete or covered immediate denture includes after delivery adjustments and tissue conditioning at no additional cost for the first six months after placement if the Enrollee continues to be eligible and the service is provided at the Contract Dentist's facility where the denture was originally delivered.
11. Immediate dentures are covered when one or more of the following conditions are present:
    a. Extensive or rampant caries are exhibited in the radiographs, **or**
    b. Severe periodontal involvement indicated, **or**
    c. Numerous teeth are missing resulting in diminished chewing ability adversely affecting the Enrollee's health.
12. Maxillofacial prosthetic services for the anatomic and functional reconstruction of those regions of the maxilla and mandible and associated structures that are missing or defective because of surgical intervention, trauma (other than simple or compound fractures), pathology, developmental or congenital malformations.
13. All maxillofacial prosthetic procedures require prior authorization for medically necessary procedures.
14. Implant services are a Benefit only under exceptional medical conditions. Exceptional medical conditions include, but are not limited to:
    a. Cancer of the oral cavity requiring ablative surgery and/or radiation leading to destruction of alveolar bone, where the remaining osseous structures are unable to support conventional dental prosthesis.
    b. Severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures or osseous augmentation procedures, and the Enrollee is unable to function with conventional prosthesis.
    c. Skeletal deformities that preclude the use of conventional prosthesis (such as arthrogryposis, ectodermal dysplasia, partial anaodontia and cleidocranial dysplasia).
15. Temporomandibular joint dysfunction procedure codes D7810-D7880 are limited to differential diagnosis and symptomatic care and require prior authorization.
16. Certain listed procedures performed by a specialist may be considered to be primary under the Enrollee's medical coverage. Dental Benefits will be coordinated accordingly.
17. Deep sedation/general anesthesia or intravenous conscious sedation/analgesia for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.

Exclusions of Benefits for Pediatric Enrollees

1. Any procedure that is not specifically listed under *Schedule A, Description of Benefits and Copayments*.
2. All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.

3. Lost or theft of full or partial dentures, space maintainers, crowns, fixed partial dentures (bridges) or other appliances.
4. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
5. Dental expenses incurred in connection with any dental procedure before the Enrollee's eligibility in the prepaid dental program. Examples include: teeth prepared for crowns, partials and dentures, root canals in progress.
6. Congenital malformations (e.g. congenitally missing teeth, supernumerary teeth, enamel and dentinal dysplasias, etc.) unless included in *Schedule A*.
7. Dispensing of drugs not normally supplied in a dental facility unless included in *Schedule A*.
8. Any procedure that in the professional opinion of the Contract Dentist, Contract Specialist, or dental plan consultant:
9. has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
10. is inconsistent with generally accepted standards for dentistry.
11. Dental services received from any dental facility other than the assigned Contract Dentist including the services of a dental specialist, unless expressly authorized or as cited under *Emergency Services*. To obtain written authorization, the Enrollee should call the Customer Service department at 800-589-4618.
12. Consultations or other diagnostic services for non-covered Benefits.
13. Single tooth implants.
14. Restorations placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension, congenital or developmental malformation of teeth.
15. Preventative, endodontic or restorative procedures are not a Benefit for teeth to be retained for overdentures.
16. Partial dentures are not a Benefit to replace missing 3rd molars, unless the 3rd molar occupies the 1st or 2nd molar position or is an abutment for a partial denture with cast clasps or rests.
17. Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth, periodontal splinting, gnathologic recordings, equilibration or treatment of disturbances of the temporomandibular joint (TMJ), unless included in *Schedule A*.
18. An initial treatment plan which involves the removal and reestablishment of the occlusal contacts of 10 or more teeth with crowns, onlays, fixed partial dentures (bridges), or any combination of these is considered to be full mouth reconstruction under the prepaid dental program. Crowns, onlays and fixed partial dentures associated with such a treatment plan are not covered Benefits. This exclusion does not eliminate the Benefit for other covered services.
19. Precious metal for removable appliances, metallic or permanent soft bases for complete dentures, porcelain denture teeth, precision abutments for removable partials or fixed partial dentures (overlays, implants, and appliances associated therewith) and personalization and characterization of complete and partial dentures.
20. Extraction of teeth, when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars.

21. Temporomandibular joint dysfunction treatment modalities that involve prosthodontia, orthodontia, and full or partial occlusal rehabilitation or TMJ dysfunction procedures solely for the treatment of bruxism.
22. Vestibuloplasty / ridge extension procedures performed on the same date of service as extractions (D7111-D7250) on the same arch.
23. Deep sedation/general anesthesia for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for intravenous conscious sedation/analgesia.
24. Intravenous conscious sedation/analgesia for covered procedures on the same date of service as analgesia, anxiolysis, inhalation of nitrous oxide or for deep sedation/general anesthesia.
25. Inhalation of nitrous oxide when administered with other covered sedation procedures.
26. Treatment or appliances that are provided by a Contract Dentist whose practice specializes in prosthodontic services.
27. Cosmetic dental care.
28. Experimental or investigational procedures.
29. Services which were provided without cost to the Enrollee by the State government or an agency thereof, or any municipality, county or other subdivisions.
30. Major surgery for fractures and dislocations
31. Additional treatment costs incurred because a dental procedure is unable to be performed in the Contract Dentist's office due to the general health and physical limitations of the Enrollee.

Medically Necessary Orthodontics for Pediatric Enrollees

1. Coverage for comprehensive orthodontic treatment requires acceptable documentation of a handicapping malocclusion as evidence by a minimum score of 26 points on the Handicapping Labio-Lingual Deviation (HLD) Index California Modification Score Sheet Form and pre-treatment diagnostic casts. Comprehensive orthodontic treatment:
    a) is limited to Enrollees who are between 13 through 18 years of age with a permanent dentition without a cleft palate or craniofacial anomaly; but
    b) may start at birth for patients with a cleft palate or craniofacial anomaly.
2. Removable appliance therapy (D8210) or fixed appliance therapy (D8220) is limited to Enrollee between 6 to 12 years of age, once in a lifetime, to treat thumb sucking and/or tongue thrust.
3. The Benefit for a pre-orthodontic treatment examination (D8660) includes needed oral/facial photographic images (D0350, D0351). Neither the Enrollee nor the plan may be charged for D0350 or D0351 in conjunction with a pre-orthodontic treatment examination.
4. The number of covered periodic orthodontic treatment visits and length of covered active orthodontics is limited to a maximum of up to:
    a) Handicapping malocclusion - Eight (8) quarterly visits;
    b) Cleft palate or craniofacial anomaly - Six (6) quarterly visits for treatment of primary dentition;
    c) Cleft palate or craniofacial anomaly - Eight (8) quarterly visits for treatment of mixed dentition; or
    d) Cleft palate or craniofacial anomaly - Ten (10) quarterly visits for treatment of permanent dentition.
    e) Facial growth management – Four (4) quarterly visits for treatment of primary dentition;

f) Facial growth management – Five (5) quarterly visits for treatment of mixed dentition;

g) Facial growth management - Eight (8) quarterly visits for treatment permanent dentition.

5. Orthodontic retention (D8680) is a separate Benefit after the completion of covered comprehensive orthodontic treatment which:

   a) Includes removal of appliances and the construction and place of retainer(s); and

   b) Is limited to one per arch after the completion of each phase of active treatment for retention of permanent dentition unless treatment was for a cleft palate or a craniofacial anomaly.

6. Copayment is payable to the Contract Orthodontist who initiates banding in a course of prior authorized orthodontic treatment. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, the Enrollee:

   a. will not be entitled to a refund of any amounts previously paid, and

   b. will be responsible for all payments, up to and including the full Copayment, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.

7. Should an Enrollee's coverage be canceled or terminated for any reason, and at the time of cancellation or termination be receiving any orthodontic treatment, the Enrollee will be solely responsible for payment for treatment provided after cancellation or termination, except:

   If an Enrollee is receiving ongoing orthodontic treatment at the time of termination, Delta Dental will continue to provide orthodontic Benefits for:

   a. For 60 days if the Enrollee is making monthly payments to the Contract Orthodontist; or

   b. Until the later of 60 days after the date coverage terminates or the end of the quarter in progress, if the Enrollee is making quarterly payments to the Contract Orthodontist.

   At the end of 60 days (or at the end of the Quarter), the Enrollee's obligation shall be based on the Contract Orthodontist's usual fee at the beginning of treatment. The Contract Orthodontist will prorate the amount over the number of months to completion of the treatment. The Enrollee will make payments based on an arrangement with the Contract Orthodontist.

SCHEDULE C

Information Concerning Benefits Under The DeltaCare USA Plan

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

(A) Deductibles	None
(B) Lifetime Maximums	None
(C) Out-of-Pocket Maximum	Individual $350.00 Multiple Child $700.00
(D) Professional Services	An Enrollee may be required to pay a Copayment amount for each procedure as shown in the Description of Benefits and Copayments, subject to the limitations and exclusions of the plan. Copayments range by category of service. Examples are as follows: Diagnostic Services — No Cost Preventive Services — No Cost Restorative Services — $ 25.00 - $ 300.00 Endodontic Services — $ 20.00 - $ 365.00 Periodontic Services — $ 10.00 - $ 265.00 Prosthodontic Services, Removable — $ 20.00 - $ 300.00 Prosthodontic Services, Fixed — $ 40.00 - $ 300.00 Oral and Maxillofacial Surgery — $ 40.00 - $ 350.00 Orthodontic Services (medically necessary only) — No Cost - $ 350.00 Adjunctive General Services — $ 10.00 - $ 210.00 **NOTE:** Some services may not be covered. Certain services may be covered only if provided by specified Dentists, or may be subject to an additional charge. Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to two in a 12 month period; Replacement of a crown is limited to once every thirty-six (36) consecutive months for Pediatric Enrollees.
(D) Outpatient Services	Not Covered
(E) Hospitalization Services	Not Covered
(F) Emergency Dental Coverage	Benefits for Emergency Services by an Out-of-Network Dentist are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.
(G) Ambulance Services	Not Covered
(H) Prescription Drug Services	Not Covered
(I) Durable Medical Equipment	Not Covered
(J) Mental Health Services	Not Covered
(K) Chemical Dependency Services	Not Covered
(L) Home Health Services	Not Covered
(M) Other	Not Covered

Each individual procedure within each category listed above, and that is covered under the plan, has a specific Copayment that is shown in the *Description of Benefits and Copayments* in this EOC.