KAISER PERMANENTE®

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

A nonprofit corporation

2027 Combined Membership Agreement, Evidence of Coverage, and Disclosure Form for Kaiser Permanente for Individuals and Families

Kaiser Permanente - Silver 70 HMO Off Exchange

A plan for members who enroll directly with Kaiser Permanente

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

2027EOCSilver70-Off

TABLE OF CONTENTS

Cost Share Summary 1
Accumulation Period 1
Deductibles and Out-of-Pocket Maximums 1
Cost Share Summary Tables by Benefit 1
CARE Plan 17
Health Care Treatment Following Rape or Sexual Assault 18
Introduction 19
About Kaiser Permanente 19
Term of this *EOC*, Renewal, and Amendment 19
Definitions 20
Premiums, Eligibility, and Enrollment 28
Premiums 28
Who Is Eligible 29
How to Enroll and When Coverage Begins 31
How to Obtain Covered Benefits 32
Routine Care 33
Urgent Care 33
Emergency Services and Care 33
Not Sure What Kind of Care You Need? 34
Your Personal Plan Physician 35
Getting a Referral 35
Prior Authorization Procedure for Certain Referrals and Services 35
Completion of Services from Non–Plan Providers 36
Travel and Lodging for Certain Services 38
Second Opinions 38
Contracts with Plan Providers 38
Receiving Care Outside of Your Home Region 39
Your ID Card 39
Timely Access to Care 39
Getting Assistance 40
Plan Facilities 41
Covered Benefits 41
Your Cost Share 42
Administered Drugs and Products 46
Ambulance and Non-Emergency Medical Transportation (“NEMT”) Services 46
Bariatric Surgery 47
Dental and Orthodontic Services 47
Dialysis Care 48
Durable Medical Equipment (“DME”) for Home Use 48
Emergency Services and Care and Urgent Care 50
Fertility Services 51
Fertility Preservation Services for Iatrogenic Infertility 51
Health Education 52
Hearing Services 53
Home Health Care 53
Hospice Care 54
Hospital Inpatient Services 54

Injury to Teeth 55
Mental Health Services 55
Office Visits 57
Ostomy and Urological Supplies 57
Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services 57
Outpatient Pharmacy Services 58
Outpatient Surgery and Outpatient Procedures 62
Preventive Services 62
Prosthetic and Orthotic Devices 63
Reconstructive Surgery 64
Rehabilitative and Habilitative Services 64
Reproductive Health Services 65
Services in Connection with a Clinical Trial 66
Skilled Nursing Facility Care 66
Substance Use Disorder Treatment 67
Telehealth Visits 68
Transplant Services 68
Vision Services for Adult Members 68
Vision Services for Pediatric Members 69
Exclusions, Limitations, Coordination of Benefits, and Reductions 70
General Exclusions and Limitations 70
Dental Exclusions and Limitations 74
Vision Exclusions and Limitations 74
Coordination of Benefits 74
Reductions 75
Post-Service Claims and Appeals 76
Who May File 77
Supporting Documents 77
Initial Claims 78
Appeals 79
External Review 80
Additional Review 80
Dispute Resolution 80
Grievances 80
Independent Review Organization for Non-Formulary Outpatient Prescription Drug Requests 83
Department of Managed Health Care Complaints 83
Independent Medical Review (“IMR”) 83
Office of Civil Rights Complaints 84
Additional Review 84
Binding Arbitration 84
Termination of Membership 87
How You May Terminate Your Membership 87
Termination Due to Loss of Eligibility 87
Termination for Cause 88
Termination for Nonpayment of Premiums 88
Termination for Discontinuance of a Product or all Products 89
Payments after Termination 89
Rescission of Membership 89
Appealing Membership Termination or Rescission 89
State Review of Membership Termination 89
Miscellaneous Provisions 89

Administration of this *EOC* ... 89
Advance Health Care Directives ... 90
Applications and Statements ... 90
Assignment ... 90
Attorney and Advocate Fees and Expenses ... 90
Catastrophic Events ... 90
Claims Review Authority ... 90
EOC Binding on Members ... 90
Governing Law ... 90
Members' Rights and Responsibilities ... 90
No Waiver ... 92
Notices Regarding Your Coverage ... 92
Overpayment Recovery ... 93
Privacy Practices ... 93
Public Policy Participation ... 93
Value-Added Services ... 93
Helpful Information ... 94
How to Obtain this *EOC* in Other Formats ... 94
Provider Directory ... 94
Online Tools and Resources ... 94
Document Delivery Preferences ... 94
How to Reach Us ... 94
How to Reach Covered California ... 96
Payment Responsibility ... 96
Pediatric Dental Services Amendment ... 97
Introduction ... 98
Definitions ... 98
How to Obtain Pediatric Dental Services ... 99
Benefits, Limitations and Exclusions ... 100
Continuity of Care ... 100
Emergency Dental Services ... 100
Urgent Dental Services ... 101
Timely Access to Care ... 101
Language Assistance Services ... 101
Specialist Services ... 102
Claims for Reimbursement ... 102
Cost Share and Other Charges ... 102
Second Opinion ... 102
Special Health Care Needs ... 103
Facility Accessibility ... 103
Dentist Compensation ... 103
Processing Policies ... 103
Teledentistry Services ... 103
Coordination of Benefits ... 104
Enrollee Complaint Procedure ... 104
SCHEDULE A - Description of Benefits and Cost Share for Pediatric Enrollees ... 106
SCHEDULE B - Limitations and Exclusions of Benefits ... 132
SCHEDULE C - Information Concerning Benefits Under The DeltaCare USA Program ... 137

Cost Share Summary

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

Accumulation Period

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

Deductibles and Out-of-Pocket Maximums

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

For services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for Covered Benefits you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles 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 Deductible	$4,700	$4,700	$9,400
Drug Deductible	$50	$50	$100
Plan Out-of-Pocket Maximum ("OOPM")	$11,650	$11,650	$23,300

Cost Share Summary Tables by Benefit

How to read the Cost Share summary tables

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

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

Administered drugs and products

Description of Administered Drugs and Products Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Whole blood, red blood cells, plasma, and platelets	No charge		✓
Allergy antigens (including administration)	$5 per visit		✓
Cancer chemotherapy drugs and adjuncts	30% Coinsurance		✓
Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood	30% Coinsurance		✓
Administered COVID-19 therapeutics from Plan Providers	No charge		✓
Administered COVID-19 therapeutics from Non-Plan Providers	50% Coinsurance	✓	
All other administered drugs and products	No charge		✓
Drugs and products administered to you during a home visit	No charge		✓

Ambulance and non-emergency medical transportation ("NEMT") services

Description of Ambulance and NEMT Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Ambulance services	$255 per trip		✓
NEMT services	No charge		✓

Dialysis care

Description of Dialysis Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Equipment and supplies for home hemodialysis and home peritoneal dialysis	No charge		✓
One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment	No charge		✓
Hemodialysis and peritoneal dialysis treatment at a Plan Facility	30% Coinsurance		✓

Durable Medical Equipment ("DME") for home use

Description of DME Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Glucose monitors for diabetes blood testing and their supplies	20% Coinsurance		✓
Peak flow meters	20% Coinsurance		✓
Insulin pumps and supplies to operate the pump	20% Coinsurance		✓
Other Base DME Items as described in this *EOC*	20% Coinsurance		✓
Supplemental DME items as described in this *EOC*	Not covered		
Retail-grade milk pumps	No charge		✓
Hospital-grade milk pumps	No charge		✓

Emergency Services and Care and Urgent Care

Description of Emergency Services and Care and Urgent Care	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency department visits	$400 per visit		✓
Urgent Care visits related to a Mental Health or Substance Use Disorder	$50 per visit		✓
Urgent Care related to a Mental Health or Substance Use Disorder program	No charge		✓
All other Urgent Care visits	$50 per visit		✓

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

Fertility Services

Description of Fertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Fertility Services	Not covered		

Health education

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

Hearing services

Description of Hearing Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hearing exams with an audiologist to determine the need for hearing correction	$50 per visit		✓
Physician Specialist Visits to diagnose and treat hearing problems	$100 per visit		✓
Hearing aids, including, fitting, counseling, adjustment, cleaning, and inspection	Not covered		

Home health care

Description of Home Health Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Home health care services (100 visits per Accumulation Period)	$45 per visit		✓

Hospice care

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

Hospital inpatient services

Description of Hospital Inpatient Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospital inpatient stays	30% Coinsurance	✓	✓

Injury to teeth

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

Mental health services

Description of Mental Health Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient mental health hospital stays	30% Coinsurance	✓	✓
Individual mental health evaluation and treatment	$50 per visit		✓
Group mental health treatment	$25 per visit		✓
Partial hospitalization	No charge		✓
Other intensive psychiatric treatment programs	No charge		✓
Residential mental health treatment services	30% Coinsurance	✓	✓
Behavioral Health Treatment for Autism Spectrum Disorder	No charge		✓
Electroconvulsive therapy	$50 per visit		✓
Transcranial magnetic stimulation	$50 per visit		✓

Office visits

Description of Office Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this “Cost Share Summary”	$50 per visit		✓

Description of Office Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Physician Specialist Visits that are not described elsewhere in this "Cost Share Summary"	$100 per visit		✓
Group appointments that are not described elsewhere in this "Cost Share Summary"	$25 per visit		✓
Acupuncture services	$50 per visit		✓

Ostomy and urological supplies

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

Outpatient imaging, laboratory, and other diagnostic and treatment services

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans	$325 per procedure		✓
Basic imaging services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds	$95 per encounter		✓
Nuclear medicine	$95 per encounter		✓
Routine retinal photography screenings	No charge		✓
Routine laboratory tests to monitor the effectiveness of dialysis	No charge		✓
Over-the-counter COVID-19 tests obtained from Plan Providers as described in this *EOC* (up to a total of 8 tests from Plan Providers and Non-Plan Providers per calendar month), not including combination COVID-19/influenza tests	No charge		✓
Over-the-counter COVID-19 tests obtained from Non-Plan Providers as described in this *EOC* (up to a total of 8 tests from Plan Providers and Non-Plan Providers per calendar month, not to exceed $12 per test, including all fees and taxes, if you obtain the test from a Non-Plan Provider)	50% Coinsurance	✓	

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Laboratory tests to diagnose or screen for COVID-19 obtained from Plan Providers	No charge		✓
Laboratory tests to diagnose or screen for COVID-19 obtained from Non-Plan Providers (except for providers of Emergency Services and Care or Out-of-Area Urgent Care)	50% Coinsurance	✓	
All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available)	$50 per encounter		✓
Diagnostic services provided by Plan Providers who are not physicians (such as EKGs and EEGs)	$95 per encounter		✓
Radiation therapy	30% Coinsurance		✓
Ultraviolet light treatments (including ultraviolet light therapy equipment as described in this *EOC*)	No charge		✓

Outpatient pharmacy services

If an item in this section is subject to a deductible there will be a "✓" or "**D**" in the "Subject to Deductible" column. "✓" indicates the item is subject to the Plan Deductible. "**D**" indicates the item is subject to the Drug Deductible.

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

Most items

Description of Most Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on Tier 1 not described elsewhere in this "Cost Share Summary"	$20 for up to a 30-day supply	$40 for up to a 100-day supply		✓
Items on Tier 2 not described elsewhere in this "Cost Share Summary"	$65 for up to a 30-day supply	$130 for up to a 100-day supply	D	✓
Items on Tier 4 not described elsewhere in this "Cost Share Summary"	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	D	✓

Base drugs, supplies, and supplements

Description of Base Drugs, Supplies and Supplements	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Hematopoietic agents for dialysis	No charge for up to a 30-day supply	Not available		✓
Elemental dietary enteral formula when used as a primary therapy for regional enteritis	No charge for up to a 30-day supply	Not available		✓
All other items on Tier 1 as described in this *EOC*	$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
All other items on Tier 2 as described in this *EOC*	$65 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
All other items on Tier 4 as described in this *EOC*	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	D	✓

Anticancer drugs and certain critical adjuncts following a diagnosis of cancer

Description of Anticancer Drugs and Certain Critical Adjuncts	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Oral anticancer drugs on Tier 1	$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on Tier 2	$65 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Oral anticancer drugs on Tier 4	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		✓

Description of Anticancer Drugs and Certain Critical Adjuncts	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Non-oral anticancer drugs on Tier 1	$20 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on Tier 2	$65 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Non-oral anticancer drugs on Tier 4	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	D	✓

Home infusion drugs

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

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

Certain state-mandated items

Description of Certain State-Mandated Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)	No charge for up to a 30-day supply	Not available		✓
Therapeutics for COVID-19 obtained from Plan Providers	No charge for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓

Description of Certain State-Mandated Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Therapeutics for COVID-19 obtained from Non-Plan Providers (except for providers of Emergency Services and Care or Out-of-Area Urgent Care)	50% Coinsurance for up to a 30-day supply	Not available	✓	
Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing	No charge for up to a 30-day supply	Not available		✓
Insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear)	$20 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy		✓
Human milk as described in this *EOC*	No charge	Not available		✓

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

Contraceptive drugs and devices

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

Description of Contraceptive Drugs and Devices	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
The following contraceptive items on Tier 2: • Spermicide • Sponges • Contraceptive gel	No charge for up to a 30-day supply	Not available		✓
Emergency contraception	No charge	Not available		✓
Diaphragms, cervical caps, and up to a 30-day supply of condoms	No charge	Not available		✓

Certain preventive items

Description of Certain Preventive Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on our Preventive Services list on our website at **kp.org/prevention** when prescribed by a Plan Provider	No charge for up to a 30-day supply	Not available		✓
Insulin on Tier 1	$20 for up to a 30-day supply	$40 for up to a 100-day supply		✓
Insulin on Tier 2	$35 for up to a 30-day supply	$70 for up to a 100-day supply		✓

Fertility and sexual dysfunction drugs

Description of Fertility and Sexual Dysfunction Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Prescription Drugs on Tier 1 prescribed in connection with Fertility Services	Not covered	Not covered		
Prescription Drugs on Tier 2 prescribed in connection with Fertility Services	Not covered	Not covered		
Prescription Drugs on Tier 4 prescribed in connection with Fertility Services	Not covered	Not covered		
Prescription Drugs on Tier 1 prescribed for sexual dysfunction disorders	$20 for up to a 30-day supply	$40 for up to a 100-day supply		✓

Description of Fertility and Sexual Dysfunction Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Prescription Drugs on Tier 2 and Tier 4 prescribed for sexual dysfunction disorders	$65 for up to a 30-day supply	$130 for up to a 100-day supply	D	✓

Weight loss drugs

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

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

Outpatient surgery and outpatient procedures

Description of Outpatient Surgery and Outpatient Procedure Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient surgery and outpatient procedures: • In any setting when licensed staff monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort • In an outpatient surgery area (an outpatient or ambulatory surgery center or same day surgery in a hospital operating room) whether or not the surgery or procedure requires a licensed staff member to monitor your vital signs as described above	30% Coinsurance		✓
Any other outpatient surgery or outpatient procedure in a medical office exam room that does not require a licensed staff member to monitor your vital signs as described above	$100 per procedure		✓

Preventive Services

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine physical exams, including well-woman, postpartum follow-up, and preventive exams for Members age 2 and older	No charge		✓
Well-child preventive exams for Members (up to and including 23 months)	No charge		✓
Normal series of regularly scheduled preventive prenatal care exams after confirmation of pregnancy	No charge		✓
Immunizations (including the vaccine) administered to you in a Plan Medical Office	No charge		✓
Immunizations (including the vaccine) for COVID-19 administered by Non-Plan Providers (except for providers of Emergency Services and Care or Out-of-Area Urgent Care)	50% Coinsurance	✓	
Tuberculosis skin tests	No charge		✓
Screening and counseling services when provided during a routine physical exam or a well-child preventive exam, such as obesity counseling, routine vision and hearing screenings, alcohol and substance abuse screenings, health education, depression screening, and developmental screenings to diagnose and assess potential developmental delays	No charge		✓
Screening colonoscopies	No charge		✓
Screening flexible sigmoidoscopies	No charge		✓
Routine imaging screenings such as mammograms	No charge		✓
Bone density CT scans	No charge		✓
Bone density DEXA scans	No charge		✓
Routine laboratory tests and screenings, such as cancer screening tests, sexually transmitted infection (“STI”) tests, cholesterol screening tests, and glucose tolerance tests	No charge		✓
Other laboratory screening tests, such as fecal occult blood tests and hepatitis B screening tests	No charge		✓

Prosthetic and orthotic devices

Description of Prosthetic and Orthotic Device Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
External prosthetic and orthotic devices as described in this *EOC*	No charge		✓
Supplemental prosthetic and orthotic devices as described in this *EOC*	Not covered		

Rehabilitative and habilitative services

Description of Rehabilitative and Habilitative Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Individual outpatient physical, occupational, and speech therapy	$50 per visit		✓
Group outpatient physical, occupational, and speech therapy	$25 per visit		✓
Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program	$50 per day		✓

Reproductive health services

Family planning services

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

Abortion and abortion-related services

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

Plan Doula services

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

Skilled nursing facility care

Description of Skilled Nursing Facility Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Skilled nursing facility services up to 100 days per benefit period*	30% Coinsurance	✓	✓

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

Substance use disorder treatment

Description of Substance Use Disorder Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient detoxification	30% Coinsurance	✓	✓
Individual substance use disorder evaluation and treatment	$50 per visit		✓
Group substance use disorder treatment	$5 per visit		✓
Intensive outpatient and day-treatment programs	No charge		✓

Description of Substance Use Disorder Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Methadone maintenance treatment	No charge		✓
Residential substance use disorder treatment	30% Coinsurance	✓	✓

Telehealth visits

Interactive video visits

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

Scheduled telephone visits

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

Vision services for Adult Members

Description of Vision Services for Adult Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	Not covered		
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$100 per visit		✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$50 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓

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

Vision services for Pediatric Members

Description of Vision Services for Pediatric Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		✓
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$100 per visit		✓
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$50 per visit		✓
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		✓
Specialty contact lenses (other than aniridia and aphakia lenses) that will provide a significant improvement in vision not obtainable with eyeglass lenses: either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (up to six months, including fitting and dispensing) in any 12-month period	No charge		
One complete pair of eyeglasses in any 12-month period, or contact lenses as described in this *EOC*, in any 12-month period	No charge		
One low vision device (including fitting and dispensing) per Accumulation Period	No charge		

CARE Plan

The California Community Assistance, Recovery, and Empowerment ("CARE") Act established a system for individuals with severe mental illness to be evaluated and given a treatment plan developed by a county behavioral health agency ("CARE Plan"). If a Member has a court-approved CARE Plan, we cover the services required under that plan when provided by Plan Providers or Non-Plan Providers at **no charge (not subject to the Plan Deductible)**, with the exception of Prescription Drugs. Prescription Drugs required under a court-approved CARE Plan are subject to the same Cost Share as Prescription Drugs prescribed by Plan Providers, as described in this Cost Share Summary, and are also subject to prior authorization by Health Plan. To inform us that you have a court-approved CARE Plan, call Member Services.

Health Care Treatment Following Rape or Sexual Assault

As required by state law, for a period of nine months after a Member initiates treatment after a rape or sexual assault, Cost Share for the following services is **no charge (not subject to the Plan Deductible)**:

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

Introduction

This *Combined Membership Agreement, Evidence of Coverage, and Disclosure Form ("EOC")* describes the health care coverage of the Kaiser Permanente - Silver 70 HMO Off Exchange plan. This *EOC,* your Premiums included in your renewal materials, and which are incorporated into this *EOC* by reference, and any amendments, constitute the legally binding contract between Kaiser Foundation Health Plan, Inc. ("Health Plan") and the Subscriber.

For benefits provided under any other program, refer to that other plan's evidence of coverage.

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

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

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

About Kaiser Permanente

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

Our medical care program

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

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

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

Your Service Area

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

Term of this *EOC*, Renewal, and Amendment

Term of this *EOC*

This *EOC* becomes effective on the membership effective date in the Subscriber's acceptance letter and will remain in effect until one of the following occurs:

- The *EOC* is amended as described under "Amendment of *EOC*" in this "Introduction" section

- There are no longer any Members in your Family who are covered under this *EOC*

Note: Your membership may terminate or be rescinded even if this *EOC* remains in effect for other covered Members of your Family. The "Termination of Membership" section explains how membership may terminate or be rescinded.

Renewal

If you comply with all of the terms of this *EOC*, we will automatically renew this *EOC* each year, effective January 1. Terms of the *EOC* will remain the same when we renew it unless we have amended the *EOC* as described under "Amendment of *EOC*" in this "Term of this *EOC*, Renewal, and Amendment" section.

Amendment of *EOC*

In accord with "Notices Regarding Your Coverage" in the "Miscellaneous Provisions" section, **we may amend this *EOC* (including Premiums and benefits) at any time by sending written notice to the Subscriber at least 15 days prior to the start of the annual open enrollment period or 60 days before the effective date of the amendment**.

An amendment may become effective earlier than the end of the period for which you have already paid your Premiums, and it may require you to pay additional Premiums for that period. All amendments are deemed accepted by the Subscriber unless the Subscriber gives us written notice of non-acceptance within 30 days of the date of the notice, in which case this *EOC* terminates the day before the effective date of the amendment.

If we notified the Subscriber that we have not received all necessary governmental approvals related to this *EOC*, we may amend this *EOC* by giving written notice to the Subscriber after receiving all necessary governmental approval, in accord with "Notices Regarding Your Coverage" in the "Miscellaneous Provisions" section. Any such government-approved provisions go into effect on January 1, 2027 (unless the government requires a later effective date).

Definitions

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

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

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

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

Ancillary Coverage: Optional benefits such as acupuncture, chiropractic, or dental coverage that may be available to Members enrolled under this *EOC.* If your plan includes Ancillary Coverage, this coverage will be described in an amendment to this *EOC* or a separate agreement from the issuer of the coverage. Note: Pediatric dental coverage is not considered to be optional Ancillary Coverage.

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

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

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
  - The National Institutes of Health
  - The federal Centers for Disease Control and Prevention
  - The Agency for Healthcare Research and Quality
  - The federal Centers for Medicare and Medicaid Services
  - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for

Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs

- ♦ A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
- ♦ One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:
  - The United States Department of Veterans Affairs
  - The United States Department of Defense
  - The United States Department of Energy

- The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration
- The study or investigation is a drug trial that is exempt from an investigational new drug application reviewed by the United States Food and Drug Administration

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

Behavioral Health Treatment for Autism Spectrum Disorder: Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs, that develop or restore, to the maximum extent practicable, the functioning of a person with autism spectrum disorder (or treat mental health conditions other than autism spectrum disorder when this treatment is clinically indicated) that meet the following criteria:

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

Charges: "Charges" means the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

EOC: This *Combined Membership Agreement, Evidence of Coverage, and Disclosure Form* document, which describes your Health Plan coverage. This *EOC,* your Premiums, which are included in your renewal materials and incorporated into this *EOC* by reference, and any amendments, constitute the legally binding contract between Health Plan and the Subscriber.

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

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

Family: A Subscriber and all of their Dependents.

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

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

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

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

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

Northern California Region Service Area

If you are enrolled in the Northern California Region, the ZIP codes below for each county are in the Service Area of your Home Region:

- Alameda County (whole county): 94501-02, 94505, 94514, 94536-46, 94550-52, 94555, 94557, 94560, 94566, 94568, 94577-80, 94586-88, 94601-15, 94617-21, 94622-24, 94649, 94659-62, 94666, 94701-10, 94712, 94720, 95377, 95391
- Amador County: 95640, 95669
- Contra Costa County (whole county): 94505-07, 94509, 94511, 94513-14, 94516-31, 94547-49, 94551, 94553, 94556, 94561, 94563-65, 94569-70, 94572, 94575, 94582-83, 94595-98, 94706-08, 94801-08, 94820, 94850
- El Dorado County: 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762
- Fresno County: 93242, 93602, 93606-07, 93609, 93611-13, 93616, 93618-19, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-30, 93737, 93740-41, 93744-45, 93747, 93750, 93755, 93760-61, 93764-65, 93771-79, 93786, 93790-94, 93844, 93888
- Kings County: 93230, 93232, 93242, 93631, 93656
- Madera County: 93601-02, 93604, 93614, 93623, 93626, 93636-39, 93643-45, 93653, 93669, 93720
- Marin County (whole county): 94901, 94903-04, 94912-15, 94920, 94924-25, 94929-30, 94933, 94937-42, 94945-50, 94952, 94956-57, 94960, 94963-66, 94970-71, 94973-74, 94976-79
- Mariposa County: 93601, 93623, 93653
- Monterey County: 93901, 93902, 93905, 93906, 93907, 93912, 93915, 93933, 93955, 93962, 95004, 95012, 95039, 95076
- Napa County (whole county): 94503, 94508, 94515, 94558-59, 94562, 94567, 94573-74, 94576, 94581, 94599, 95476
- Placer County: 95602-04, 95610, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95703, 95722, 95736, 95746-47, 95765
- Sacramento County (whole county): 94203-06, 94209, 94229-30, 94232, 94235-37, 94239-40, 94244, 94247-50, 94252, 94254, 94256-59, 94261-63, 94267-69, 94271, 94273-74, 94277-80, 94283-85, 94287-90, 94293-98, 94571, 95608-11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638-39, 95641, 95652, 95655, 95660, 95662, 95670-71, 95673, 95678, 95680, 95683, 95690, 95693, 95741-42, 95757-59, 95763, 95811-38, 95840-43, 95851-53, 95860, 95864-67, 95894, 95899
- San Francisco County (whole county): 94102-05, 94107-12, 94114-34, 94137, 94139-47, 94151, 94158-61, 94163-64, 94172, 94177, 94188
- San Joaquin County (whole county): 94514, 95201-13, 95215, 95219-20, 95227, 95230-31, 95234, 95236-37, 95240-42, 95253, 95258, 95267, 95269, 95296-97, 95304, 95320, 95330, 95336-37, 95361, 95366, 95376-78, 95385, 95391, 95632, 95686, 95690
- San Mateo County (whole county): 94002, 94005, 94010-11, 94014-21, 94025-28, 94030, 94037-38, 94044, 94060-66, 94070, 94074, 94080, 94083, 94128, 94303, 94401-04, 94497
- Santa Clara County: 94022-24, 94035, 94039-43, 94085-89, 94301-06, 94309, 94550, 95002, 95008-09, 95011, 95013-15, 95020-21, 95026, 95030-33, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95076, 95101, 95103, 95106, 95108-13, 95115-36, 95138-41, 95148, 95150-61, 95164, 95170, 95172-73, 95190-94, 95196
- Santa Cruz County (whole county): 95001, 95003, 95005-7, 95010, 95017-19, 95033, 95041, 95060-67, 95073, 95076-77
- Solano County (whole county): 94503, 94510, 94512, 94533-35, 94571, 94585, 94589-92, 95616, 95618, 95620, 95625, 95687-88, 95690, 95694, 95696

- Sonoma County: 94515, 94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999, 95401-07, 95409, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, 95492
- Stanislaus County (whole county): 95230, 95304, 95307, 95313, 95316, 95319, 95322-23, 95326, 95328-29, 95350-58, 95360-61, 95363, 95367-68, 95380-82, 95385-87, 95397
- Sutter County: 95626, 95645, 95659, 95668, 95674, 95676, 95692, 95836-7
- Tulare County: 93618, 93631, 93646, 93654, 93666, 93673
- Yolo County: 95605, 95607, 95612, 95615-18, 95620, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99
- Yuba County: 95692, 95903, 95961

Southern California Region Service Area

If you are enrolled in the Southern California Region, the ZIP codes below for each county are in the Service Area of your Home Region:

- Imperial County: 92274-75
- Kern County: 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
- Los Angeles County: 90001-84, 90086-89, 90091, 90093-96, 90099, 90134, 90140, 90189, 90201-02, 90205, 90209-13, 90220-24, 90230-32, 90239-42, 90245, 90247-51, 90254-55, 90260, 90262-67, 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, 90831-33, 90840, 90842, 90844, 90846-48, 90853, 90895, 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, 91324-28, 91330-31, 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, 91499, 91501-08, 91510, 91521-23, 91601-10, 91614-18, 91702, 91706, 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
- Orange County (whole county): 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, 92728, 92735, 92780-82, 92799, 92801-09, 92811-12, 92814-17, 92821-23, 92825, 92831-38, 92840-46, 92856-57, 92859, 92861-71, 92885-87, 92899
- Riverside County: 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, 92513-14, 92516-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92589-93, 92595-96, 92599, 92860, 92877-83
- San Bernardino County: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91766, 91784-86, 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
- San Diego County: 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, 92191-93, 92195-99
- Tulare County: 93238, 93261
- Ventura County: 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, your Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside your Service Area unless that other county is listed above and that ZIP code is also listed for that other county.

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

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

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

- A Plan Physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition does not prevent testing and diagnosis of infertility before the 12-month or 6-month period to establish infertility in the third bullet
- A person's inability to reproduce either as an individual or with their partner without medical intervention
- The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this section, "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility

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

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

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

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

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

Life-Threatening: Either or both of the following:

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

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

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

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

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

Member: A Subscriber or Dependent of a Subscriber, who has enrolled in this Kaiser Permanente for Individuals and Families plan, and whose coverage is active.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Plan Optometrist: An optometrist who is a Plan Provider.

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

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

Plan Physician: Any licensed physician who is a partner or employee of the Medical Group, or any licensed physician who contracts to provide Covered Benefits to

Members (but not including physicians who contract only to provide referral services).

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

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

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

Premiums: Periodic membership charges paid by or on behalf of each Member. Premiums are in addition to any Cost Share. Your Premium is sometimes referred to as your "rate." "Full Premiums" means 100 percent of Premiums for all of the coverage issued to each enrolled Member.

Prescription Drug: A drug approved by the federal Food and Drug Administration ("FDA") for sale to consumers that requires a prescription and is not provided for use on an inpatient basis. The term "drug" or "prescription drug" includes the following:

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

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

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

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

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

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

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

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

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

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

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the

provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The person to whom the Subscriber is legally married under applicable law. For the purposes of this *EOC*, the term "Spouse" includes the Subscriber's domestic partner. "Domestic partners" are two people who are registered and legally recognized as domestic partners by California.

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

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

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

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

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

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

Premiums, Eligibility, and Enrollment

Premiums

Only Members for whom we have received Full Premiums are entitled to coverage under this *EOC*, and then only for the period for which we have received the required Premium payment. You must prepay the Premiums included in your renewal materials for each month on or before the last day of the preceding month. You may be assessed a charge for a Premium payment that is declined by your financial institution. If we do not receive your Premium payment by the due date, we may terminate your membership as described under "Termination for Nonpayment of Premiums" in the "Termination of Membership" section.

Effective date of Premiums for new Members

Premiums are effective on the same day that the new Member's coverage is effective. For effective dates for open enrollment, see "Open enrollment period" under "How to Enroll and When Coverage Begins" in this "Premiums, Eligibility, and Enrollment" section. For information about effective dates for special enrollment, visit **kp.org/specialenrollment** or call Member Services.

When your Premiums may change

We may amend the Premiums included in your renewal materials by sending written notice at least 60 days before the effective date of the amendment, as described under "Amendment of *EOC*" under "Term of this *EOC*, Renewal, and Amendment" in the "Introduction" section.

Also, your Premiums may change as follows:

- When you add a new Dependent, Premiums are effective as described under "Effective date of Premiums for new Members" in this "Premiums" section
- When you drop Dependents or move to a new rate area, any change in Premiums will take effect at the same time the change becomes effective
- When you progress to a new age band, any change in Premiums will take effect upon renewal. Note: If your application for health coverage provided an incorrect birth date, Premiums will be adjusted to reflect the correct age as of the effective date of coverage for the current plan year

To see how these types of changes may impact your rate, see **kp.org/compareplans** or call Member Services.

If a government agency or other taxing authority imposes or increases a tax or other charge (other than a tax on or measured by net income) upon Health Plan or Plan Providers (or any of their activities), we may increase Premiums to include your share of the new or increased tax or charge by sending written notice to the Subscriber at least 30 days prior to the effective date of the change. Your share is determined by dividing the number of enrolled Members in your Family by the total number of Members enrolled in your Service Area.

Premiums for Ancillary Coverage

If you have selected Ancillary Coverage provided under any other program, the Premium for that Ancillary Coverage will be billed together with required Premiums for coverage under this *EOC*. Full Premiums will then also include Premium for Ancillary Coverage. This means if you do not pay the Full Premiums owed by the due date, we may terminate your membership under this *EOC* and any Ancillary Coverage, as described in the "Termination for Nonpayment of Premiums" section.

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Who Is Eligible" section.

Service Area eligibility requirements if you are enrolled through Covered California

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

Service Area eligibility requirements if you are enrolled directly with Kaiser Permanente

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

If the Subscriber moves from the Service Area of their Home Region to the other California Region, we will transfer the membership of the Subscriber and all Dependents to the Individuals and Families Plan in that Region that is most similar to this plan. All terms and conditions in your application for health coverage, including the Conditions of Acceptance and Arbitration Agreement, will continue to apply. We will provide the Subscriber with the effective date of coverage and a Kaiser Permanente ID card for each Member of the Family with a new medical record number on it. For more information about premiums that apply in the other California Region, refer to **kp.org/compareplans** or call Member Services.

If the Subscriber moves to the Service Area of a Region outside California, they may be able to apply for membership for the Subscriber and all Dependents in that Region by contacting the member or customer service department there, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*.

If the Subscriber moves anywhere else outside their Service Area after enrollment, the Subscriber and all Dependents can continue membership as long as they meet all other eligibility requirements. However, you must receive Covered Benefits from Plan Providers inside your Service Area, except as described in the sections listed below for the following services:

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

- Hospice care as described under "Hospice Care" in the "Covered Benefits" section

Eligibility as a Dependent

Enrolling a Dependent

If you are a Subscriber, the following persons are eligible to enroll as your Dependents:

- Your Spouse
- Your or your Spouse's Dependent children, who meet the requirements described under "Age limit of Dependent children," if they are any of the following:
  - biological children
  - stepchildren
  - adopted children
  - children placed with you for adoption
  - foster children if you or your Spouse have the legal authority to direct their care
  - children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)
- Children whose parent is a Dependent child under your family coverage (including adopted children and children placed with your Dependent child for adoption or foster care), if they meet all of the following requirements:
  - they are not married and do not have a domestic partner (for the purposes of this requirement only, "domestic partner" means someone who is registered and legally recognized as a domestic partner by California)
  - they meet the requirements described under "Age limit of Dependent children"
  - they receive all of their support and maintenance from you or your Spouse
  - they permanently reside with you or your Spouse
- Parents or stepparents who meet the definition of a qualifying relative under Section 152(d) of Title 26 of the United States Code and who live or reside within your Service Area

If you have a baby

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

Age limit of Dependent children

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

Dependent children are eligible to remain on the plan through the end of the calendar year, as long as they are under the age limit on the effective date of this *EOC*.

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

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

Overage Dependent certification

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

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

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

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

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

This plan is not intended for most Medicare beneficiaries. If you are (or become) eligible for Medicare during the term of this *EOC*, you may be able to enroll in Kaiser Permanente Senior Advantage. The premiums and coverage under our Senior Advantage plan are different from those under this *EOC*. For information about how to apply for a plan through Medicare, visit **kp.org/medicare**.

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, we will send you a notice that tells you whether your drug coverage under this *EOC* is creditable prescription drug coverage at the times required by the Centers for Medicare & Medicaid Services and upon your request. For more information, call Member Services.

How to Enroll and When Coverage Begins

How to enroll through Covered California

To request enrollment, you must submit a completed application to Covered California along with any other information that they require. For information about how to apply for a plan through Covered California, visit the Covered California website at **CoveredCA.com** or call the Covered California Service Center at the number listed under "How to Reach Covered California" in the "Helpful Information" section.

How to enroll directly through Kaiser Permanente

When you first request enrollment, you must submit a completed application for health coverage for the Subscriber and any Dependents. If you are eligible for Medicare Part A or are enrolled in Medicare Part B, you are not eligible to apply for new KPIF coverage. The annual open enrollment period is described under "Open enrollment period" in this "How to Enroll and When Coverage Begins" section. For information about special enrollment periods, refer to "Special enrollment" in this "How to Enroll and When Coverage Begins" section. If you are requesting enrollment in accord with the "Special enrollment" section, you may be required to provide proof that you have experienced a qualifying life event.

If you are already enrolled as a Subscriber and want to request enrollment of a Dependent during the annual open enrollment period or a special enrollment period, you must submit a completed account change form. The annual open enrollment period is described under "Open enrollment period" in this "How to Enroll and When Coverage Begins" section. For information about special enrollment periods, refer to "Special enrollment" in this "How to Enroll and When Coverage Begins" section. If you are requesting enrollment of a Dependent in accord with the "Special enrollment" section, you may be required to provide proof that you have experienced a qualifying life event.

Note: During the enrollment process if we discover that you or someone on your behalf intentionally provided incomplete or incorrect material information on your enrollment application, we will rescind your membership. This means that we will completely cancel your membership so that no coverage ever existed. If your membership is rescinded, you must pay full Charges for any Covered Benefits you received. Refer to "Rescission of Membership" in the "Termination of Membership" section for details.

Selecting and switching your benefit plan

When you first enroll, you must select a plan to enroll in. You cannot switch plans until the next open enrollment period unless you qualify for special enrollment (for more information, see "Special Enrollment" in this "How to Enroll and When Coverage Begins" section). Also, you cannot switch plans if you are eligible for Medicare Part A or are enrolled in Medicare Part B because you are not eligible to apply for new KPIF coverage. If you qualify for special enrollment and are thinking about switching to a different plan, examine your coverage options carefully. Cost Share and Premiums vary between plans. To learn more about other plans we offer, call Member Services. If you want a copy of the membership agreement and evidence of coverage for another plan we offer, ask the representative to send you one.

Open enrollment period

You may apply for enrollment by submitting an application or account change form as described in the "How to Enroll and When Coverage Begins" section during the open enrollment period. The open enrollment period is established by California law each year. Visit **kp.org/compareplans** or **CoveredCA.com** for more information on the open enrollment period, including applicable dates. If your application is accepted during the open enrollment period, we will notify you of your membership effective date. If you have questions, call Member Services.

Special enrollment

You may apply for enrollment as a Subscriber (and existing Subscribers may apply to enroll Dependents) by submitting an application or account change form, as described in this "How to Enroll and When Coverage Begins" section, if one of the people applying for coverage experiences a qualifying life event. For the most current list of special enrollment qualifying life events, deadlines for submitting your request for enrollment, and information about effective dates, visit **kp.org/specialenrollment** or call Member Services to request a printed copy.

How to appeal if your application is declined

If your request for enrollment is declined, you may appeal this decision using one of the following processes:

- If we decline your request for enrollment, you may appeal by filing a grievance. Refer to "Grievances" in the "Dispute Resolution" section for information on how to file a grievance
- If Covered California declines your request for enrollment in coverage offered through Covered California, you may appeal by following the process described in Covered California's notice

How to Obtain Covered Benefits

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

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

As a Member, you are enrolled in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), called your Home Region. The coverage information in this *EOC* applies when you obtain care in the Service Area of your Home Region.

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

Routine Care

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

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

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

Urgent Care

Inside your Service Area

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

Out-of-Area Urgent Care

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

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

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

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

Emergency Services and Care

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

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

Post-Stabilization Care

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

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

- **Post-Stabilization Care authorization at a Cigna Healthcare PPO Network facility outside of a Kaiser Permanente State:** If you are outside of a Kaiser Permanente state and you were treated at a Cigna Healthcare PPO Network facility for an Emergency Medical Condition or Psychiatric Emergency Medical Condition, Cigna Payer Solutions is responsible for authorizing any Post-Stabilization Care
- **Post-Stabilization Care authorization from other Non-Plan Providers (including Cigna Healthcare PPO Network facilities inside a Kaiser**

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

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

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

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

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

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

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

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

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

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

Not Sure What Kind of Care You Need?

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

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

- They can tell you what to do if you need care and a Plan Medical Office is closed or you are outside your Service Area

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

Your Personal Plan Physician

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

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

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

Getting a Referral

Referrals to Plan Providers

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

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

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

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

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

Standing referrals

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

Prior Authorization Procedure for Certain Referrals and Services

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

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

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

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

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

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

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

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

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

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

Health Plan's decision time frames

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

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

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

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

Completion of Services from Non–Plan Providers

New Member

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

effective, you may be eligible for limited coverage of that Non–Plan Provider's services.

Terminated provider

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

Eligibility

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

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these services until the acute condition ends
- Serious chronic conditions until the earlier of (1) 12 months from your effective date of coverage if you are a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - it persists without full cure
  - it worsens over an extended period of time
  - it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these services for the duration of the pregnancy and immediate postpartum care
- Mental health conditions in pregnant Members that occur, or can impact the Member, during pregnancy or during the postpartum period including, but not limited to, postpartum depression. We may cover completion of these services for up to 12 months from the mental health diagnosis or from the end of pregnancy, whichever occurs later
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these services for the duration of the illness
- Children under age 3. We may cover completion of these services until the earlier of (1) 12 months from the child's effective date of coverage if the child is a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your effective date of coverage if you are a new Member or within 180 days of the termination date of the terminated provider

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

- Your Health Plan coverage is in effect on the date you receive the services
- For new Members, your prior plan's coverage of the provider's services has ended or will end when your coverage with us becomes effective
- You are receiving Covered Benefits in one of the cases listed above from a Non–Plan Provider on your effective date of coverage if you are a new Member, or from the terminated Plan Provider on the provider's termination date
- For new Members, your prior coverage is no longer available in the market, including a health benefit plan that was withdrawn from any portion of the market
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing services inside your Service Area (the requirement that the provider agree to providing services inside your Service Area doesn't apply if you were receiving Covered Benefits from the provider outside your Service Area when the provider's contract terminated)
- The services to be provided to you would be Covered Benefits under this *EOC* if provided by a Plan Provider
- You request completion of services in accord with the "Completion of Covered Services" policy on **kp.org**

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

More information

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

Travel and Lodging for Certain Services

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

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

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

Second Opinions

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

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

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

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

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

Contracts with Plan Providers

How Plan Providers are paid

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

Financial liability

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

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

Breach of contract

We will give you written notice within a reasonable time if any contracted provider breaches a contract with us, or is not able to provide contracted services, if you might be materially and adversely affected.

Termination of a Plan Provider's contract

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for the Covered Benefits you receive from that provider until we make arrangements

for the services to be provided by another Plan Provider and notify you of the arrangements. You may be eligible to receive Covered Benefits from a terminated provider; refer to "Completion of Services from Non–Plan Providers" in this "How to Obtain Covered Benefits" section.

Provider groups and hospitals

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

Receiving Care Outside of Your Home Region

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

Receiving care in another Kaiser Permanente Service Area

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

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

Receiving care outside of any Kaiser Permanente Service Area

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

Your ID Card

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

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

Timely Access to Care

Standards for appointment availability

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

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

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

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

Timely access to telephone assistance

DMHC developed the following standards for answering telephone questions:

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

Interpreter services

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

Access to mental health services and substance use disorder treatment

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

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

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

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

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

Getting Assistance

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

Member Services

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

- Your Health Plan benefits
- How to make your first medical appointment

- What to do if you move
- How to replace your Kaiser Permanente ID card

You can reach Member Services in the following ways:

Call **1-800-464-4000 (**English and more than 150 languages using interpreter services**)**
1-800-788-0616 (Spanish**)**
1-800-757-7585 (Chinese dialects**)**
TTY users call **711**

24 hours a day, seven days a week (closed holidays)

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

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

Website kp.org

Cost Share estimates

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

Plan Facilities

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

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

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

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

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

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call Kaiser Permanente Member Services at 1-800-464-4000 (TTY users call 711), to ensure that you can obtain the health care services that you need.

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

Covered Benefits

This section describes Covered Benefits under this *EOC*.

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

- You are a Member on the date that you receive the services
- The services are Medically Necessary

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

Refer to:

- The "How to Obtain Covered Benefits" section for information about how to obtain covered Emergency Services and Care, Post-Stabilization Care, and Out-of-Area Urgent Care
- Our Provider Directory for the types of Covered Benefits that are available from each Plan Facility, because some facilities provide only specific types of Covered Benefits

Your Cost Share

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

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

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

General rules, examples, and exceptions

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

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

the Cost Share when the item is ordered. For Prescription Drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription

Cost Share for services received by newborn children of a Member

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

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

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

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

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

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

In some cases, a Non–Plan Provider may be involved in the provision of Covered Benefits at a Plan Facility or a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the Covered Benefits you

receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the services and file a claim for reimbursement. For information on how to file a claim, see the "Post-Service Claims and Appeals" section.

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

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

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

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

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

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

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

Getting an estimate of your Cost Share

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

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

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

Drug Deductible

Refer to the "Cost Share Summary" section of this *EOC* 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 Covered Benefits subject to the Plan Deductible until you reach one of the Plan Deductible amounts listed in the "Cost Share Summary" section of this *EOC*.

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 deductible 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 they reach the deductible amount for any one Member, or the entire Family reaches the 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 "Covered Benefits" section.

Services that are subject to the Plan Deductible

The Cost Share that you must pay for Covered Benefits is described in the "Cost Share Summary" section of this *EOC*. When the "Cost Share Summary" indicates the services are 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 "no charge" and the "Cost Share Summary" indicates the services are 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 Benefits that are subject to this Plan Deductible under this *EOC*.

Copayments and Coinsurance

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

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

Plan Out-of-Pocket Maximum

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

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

Payments that count toward the Plan Out-of-Pocket Maximum

Any payments you make toward the Plan Deductible or Drug Deductible, if applicable, apply toward the maximum.

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

If your plan includes pediatric dental services described in a Pediatric Dental Services Amendment to this *EOC*, those services will apply toward the maximum. If your plan has a Pediatric Dental Services Amendment, it will be attached to this *EOC*, and it will be listed in the *EOC's* Table of Contents.

Accrual toward deductibles and out-of-pocket maximums

To see how close you are to reaching your deductibles, if any, and out-of-pocket maximums, use our online Out-of-Pocket Summary tool at **kp.org** or call Member Services. We will provide you with accrual balance information for every month that you receive services until you reach your individual out-of-pocket maximums or your Family reaches the Family out-of-pocket maximums.

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

Administered Drugs and Products

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

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

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

For the following services, refer to these sections

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

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

Emergency ambulance services

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

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

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

Non-emergency ambulance services

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

NEMT services

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

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

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

Bariatric Surgery

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

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

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

For the following services, refer to these sections

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

Dental and Orthodontic Services

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

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

Dental services for radiation treatment

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

Dental services for transplants

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

Dental anesthesia

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

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

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

Dental and orthodontic services for cleft palate

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

- The services are an integral part of a reconstructive surgery for cleft palate that we are covering under "Reconstructive Surgery" in this "Covered Benefits" section ("cleft palate" includes cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate)
- A Plan Provider provides the services or the Medical Group provides a referral to a Non–Plan Provider

who is a dentist or orthodontist (as described under "Prior Authorization Procedure for Certain Referrals and Services" in the "How to Obtain Covered Benefits" section)

For the following services, refer to these sections

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

Dialysis Care

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

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

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

Covered dialysis care does not include the following services:

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

For the following services, refer to these sections

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

Durable Medical Equipment ("DME") for Home Use

DME coverage rules

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

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

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

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

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

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

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

Base DME Items

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

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

Supplemental DME items

We cover only Base DME Items under this *EOC*. Except for lactation supplies, any other DME items are supplemental DME items, and are not covered. Coverage for lactation supplies is described under "Lactation supplies" in this "Durable Medical Equipment ("DME") for Home Use" section.

Lactation supplies

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

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

Outside your Service Area

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

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

For the following services, refer to these sections

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

- Insulin and any other drugs administered with an infusion pump (refer to "Outpatient Pharmacy Services")

Emergency Services and Care and Urgent Care

We cover the following services:

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

Your Cost Share

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

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

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

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

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

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

We will reduce any payment we make to you or the Non–Plan Provider by applicable Cost Share. Also, we will reduce our payment by any amounts paid or payable (or that in the absence of this plan would have been payable) for the services under any insurance policy, or any other contract or coverage, or any government program except Medicaid. If payment under the other insurance or program is not made within a reasonable period of time, we will pay for covered Emergency Services and Care, Post-Stabilization Care, and Out-of-Area Urgent Care received from Non–Plan Providers if you:

- Assign all rights to payment to us and agree to cooperate with us in obtaining payment
- Allow us to obtain any relevant information from the other insurance or program
- Provide us with any information and assistance we need to obtain payment from the other insurance or program

For the following services, refer to these sections

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

Fertility Services

Fertility Services are not covered under this *EOC*, including the following:

- Diagnosis and treatment of Infertility
- Fertility treatment, such as artificial insemination and in vitro fertilization ("IVF")

For the following services, refer to these sections

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

Fertility Preservation Services for Iatrogenic Infertility

Standard Fertility Preservation Services are covered in the following situations:

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

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

We cover the following Standard Fertility Preservation Services:

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

- for a Member who is 26 years or older: three years

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

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

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

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

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

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

For the following services, refer to these sections

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

Health Education

We cover a variety of health education counseling, programs, and materials that your personal Plan

Physician or other Plan Providers provide during a visit covered under another part of this *EOC*.

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

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

Hearing Services

We cover the following:

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

Hearing aids

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

Note: The Hearing Aid Coverage for Children Program (HACCP) offers state-funded hearing aid coverage to eligible children and youth, ages 0-20. To learn more and apply, visit **www.dhcs.ca.gov/HACCP**.

For the following services, refer to these sections

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

Home Health Care

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

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

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

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

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

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

Covered home health care does not include the following services:

- Care of a type that an unlicensed family member or other layperson could provide safely and effectively

in the home setting after receiving appropriate training. This care is excluded even if we would cover the care if it were provided by a qualified medical professional in a hospital or a Skilled Nursing Facility

- Care in the home if the home is not a safe and effective treatment setting

For the following services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder (refer to "Mental Health Services")
- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Hospice Care

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

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

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

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

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

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

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

Hospital Inpatient Services

We cover the following inpatient services in a Plan Hospital, when the services are generally and

customarily provided by acute care general hospitals inside your Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, refer to "Outpatient Pharmacy Services" in this "Covered Benefits" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and other diagnostic and treatment services, including MRI, CT, and PET scans
- Whole blood, red blood cells, plasma, platelets, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, refer to "Office Visits" in this "Covered Benefits" section)
- Behavioral Health Treatment for Autism Spectrum Disorder
- Respiratory therapy
- Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation program)
- Medical social services and discharge planning

For the following services, refer to these sections

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

Injury to Teeth

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

Mental Health Services

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

Outpatient mental health services

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

- Individual and group mental health evaluation and treatment, including treatment of first episode psychosis

- Psychological testing when necessary to evaluate a Mental Health Condition
- Outpatient services for the purpose of monitoring drug therapy
- Behavioral Health Treatment for Autism Spectrum Disorder
- Electroconvulsive therapy
- Transcranial magnetic stimulation

Intensive psychiatric treatment programs

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

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

Residential treatment

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

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

Gender-affirming services

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

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

Inpatient psychiatric hospitalization

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

Services from Non-Plan Providers

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

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

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

For the following services, refer to these sections

- Behavioral Health Treatment for Autism Spectrum Disorder provided during a covered stay in a Plan

Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")

- Drugs administered by a mental health provider to treat a mental health condition (refer to "Administered Drugs and Products")
- Durable medical equipment (refer to "Durable Medical Equipment ('DME') for Home Use")
- Outpatient laboratory and sleep studies (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Prescription Drugs (refer to "Outpatient Pharmacy Services")
- Telehealth Visits (refer to "Telehealth Visits")

Office Visits

We cover the following:

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

For the following services, refer to these sections

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

Ostomy and Urological Supplies

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

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

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

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

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services

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

- Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans
- Basic imaging services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds
- Nuclear medicine
- Routine retinal photography screenings
- Laboratory tests, including tests to monitor the effectiveness of dialysis and tests for specific genetic disorders for which genetic counseling is available
- Diagnostic services provided by Plan Providers who are not physicians (such as EKGs, EEGs, and sleep studies)
- Radiation therapy
- Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if (1) the equipment has been approved for you through the Plan's prior authorization process, as described under "Prior Authorization Procedure for Certain Referrals and Services" in the "How to Obtain Covered Benefits" section and (2) the equipment is provided inside your Service Area. (Coverage for ultraviolet light therapy equipment is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment,

and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.)

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

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

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

- Ultraviolet light therapy comfort, convenience, or luxury equipment or features
- Repair or replacement of ultraviolet light therapy equipment due to loss, theft, or misuse

For the following services, refer to these sections

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

Outpatient Pharmacy Services

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

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

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

How to obtain covered items

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

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

Refills

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

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

Day supply limit

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

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

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

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

About the drug formulary

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

Formulary exception process

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

Continuity drugs

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

About drug tiers

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

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

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

Note:

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

General rules about coverage and your Cost Share

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

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

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

Note:

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

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

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

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

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

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

Manufacturer coupon program
For Prescription Drugs or items that are covered under this "Outpatient Pharmacy Services" section and obtained at a Plan Pharmacy, you may be able to use

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

Drug Deductible

In any Accumulation Period, you must pay Charges for any items covered under this "Outpatient Pharmacy Services" section that are subject to the Drug Deductible until you meet the applicable Drug Deductible amount listed in the "Cost Share Summary" section of this *EOC*.

The only payments that count toward this Drug Deductible are those you make under this *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 Benefits is described in the "Cost Share Summary" section of this *EOC*. When the "Cost Share Summary" indicates the services are 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," but the services are subject to the Drug Deductible, your Cost Share for those services will be Charges until you reach the Drug Deductible.

Base drugs, supplies, and supplements

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

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

Formulas and food

We cover the following outpatient formulas and food:

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

For the following services, refer to these sections

- Administered contraceptives (refer to "Reproductive Health Services")
- Drugs prescribed for abortion or abortion-related services (refer to "Reproductive Health Services")
- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment ("DME") for Home Use")
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Services" and "Skilled Nursing Facility Care")
- Drugs prescribed for pain control and symptom management of the terminal illness for Members who

are receiving covered hospice care (refer to "Hospice Care")

- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment ("DME") for Home Use")
- Outpatient administered drugs that are not abortion or abortion-related services or contraceptives (refer to "Administered Drugs and Products")

Outpatient Surgery and Outpatient Procedures

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

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

For the following services, refer to these sections

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

Preventive Services

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

- Services recommended by the United States Preventive Services Task Force with rating of "A" or "B." The complete list of these services can be found at **uspreventiveservicestaskforce.org**
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. The complete list of recommended immunizations can be found at **cdc.gov**
- Preventive services recommended by the Health Resources and Services Administration and incorporated into the Affordable Care Act. The complete list of these services can be found at **hrsa.gov/womens-guidelines**

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

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

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

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

For the following services, refer to these sections

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

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices coverage rules

Most prosthetic and orthotic devices are not covered under this *EOC*.

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

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

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

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

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

Base prosthetic and orthotic devices

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

Internally implanted devices

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

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

External devices

We cover the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- After Medically Necessary removal of all or part of a breast:
  - ♦ prostheses, including custom-made prostheses when Medically Necessary
  - ♦ up to three brassieres required to hold a prosthesis in any 12-month period

- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Enteral pump and supplies
- Tracheostomy tube and supplies
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

Supplemental prosthetic and orthotic devices

Under this *EOC*, we cover only the prosthetic and orthotic devices listed under "Base prosthetic and orthotic devices" in this "Prosthetic and Orthotic Devices" section. Any other prosthetic and orthotic devices are supplemental devices, and are not covered under this *EOC*.

For the following services, refer to these sections

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

Reconstructive Surgery

We cover the following reconstructive surgery services:

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

Covered reconstructive surgery does not include the following services:

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

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

For the following services, refer to these sections

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

Rehabilitative and Habilitative Services

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

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

We cover the following services:

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

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

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

For the following services, refer to these sections

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

Reproductive Health Services

Family planning services

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

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

Plan Doula services

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

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

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

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

Covered Plan Doula services do not include the following services:

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

Abortion and abortion-related services

We cover the following services:

- Surgical abortion

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

For the following services, refer to these sections

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

Services in Connection with a Clinical Trial

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

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

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

Skilled Nursing Facility Care

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

We cover the following services:

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

For the following services, refer to these sections

- Outpatient imaging, laboratory, and other diagnostic and treatment services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

- Outpatient physical, occupational, and speech therapy (refer to "Rehabilitative and Habilitative Services")

Substance Use Disorder Treatment

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

Outpatient substance use disorder treatment

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

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

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

Residential treatment

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

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

Inpatient detoxification

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

Services from Non-Plan Providers

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

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

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

For the following services, refer to these sections

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

Telehealth Visits

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

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

- Interactive video visits
- Scheduled telephone visits

Transplant Services

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

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

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

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

For the following services, refer to these sections

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

Vision Services for Adult Members

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

We cover the following for Adult Members:

- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical services

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

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this

"Vision Services for Adult Members" section). Also, covered optical services do not include the following services:

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

Special contact lenses
We cover the following:

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

Low vision devices

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

For the following services, refer to these sections

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

Vision Services for Pediatric Members

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

We cover the following for Pediatric Members:

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

Optical services

We cover the services described in this "Optical services" section when received from Plan Medical Offices or Plan Optical Sales Offices. Covered optical services do not include the following services:

- 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
- 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
- Items and services to reshape the eye or correct refractive defects of the eye

Special contact lenses
We cover the following:

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

- For other specialty contact lenses that will provide a significant improvement in your vision not obtainable with eyeglass lenses, we cover either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (up to six months, including fitting and dispensing) in any 12-month period

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 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 standard single vision, lined 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. 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) 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 six-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.

For the following services, refer to these sections

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

Exclusions, Limitations, Coordination of Benefits, and Reductions

This Kaiser Permanente for Individuals and Families plan does not cover the services or supplies listed below that are excluded from coverage or exceed limitations as described in this *EOC*.

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

These exclusions and limitations do not apply when covered by this Kaiser Permanente for Individuals and Families plan or required by law.

General Exclusions and Limitations

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

Chiropractic services
This Kaiser Permanente for Individuals and Families plan does not cover chiropractic services, except as required by law, unless you have coverage for supplemental chiropractic services as described in an amendment to this *EOC*.

Clinical trials

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

Coverage of Approved Clinical Trials does not include the following:

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

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

Cosmetic services

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

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

This cosmetic services exclusion does not apply to the following:

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

Custodial or domiciliary care

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

This exclusion does not apply to the following:

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

Dental services

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

Dietary or nutritional supplements

This Kaiser Permanente for Individuals and Families plan does not cover dietary or nutritional supplements, except as described under "Outpatient Pharmacy Services" or "Preventive Services" in the "Covered Benefits" section or as required by law.

Disposable supplies for home use

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

Experimental Services or Investigational Services

This Kaiser Permanente for Individuals and Families plan does not cover Experimental Services or Investigational Services, except as described below, or as required by law.

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

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

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

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

- Reference to relevant federal regulations, such as those contained in Title 42, Code of Federal Regulations, Chapter IV (Health Care Financing Administration) and Title 21, Code of Federal Regulations, Chapter I (Food and Drug Administration)
- Consultation with provider organizations, academic and professional specialists pertinent to the specific service
- Reference to current medical literature

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

Qualifications

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

External, Independent Review Process

If the health plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the health plan will notify you within five business days of its decision and your opportunity to request external review of the health plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you

may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the health plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

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

Hearing aids

This Kaiser Permanente for Individuals and Families plan does not cover hearing aids, except as described in this *EOC* under "Hearing Services" in the "Covered Benefits" section, or as required by law.

Non-licensed or non-certified providers

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

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

Personal or comfort items

This Kaiser Permanente for Individuals and Families plan does not cover personal or comfort items, such as internet, telephones, personal hygiene items, food delivery services, or services to help with personal care, except as required by law.

Prescription Drugs / Outpatient Prescription Drugs

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

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

Private duty nursing

This Kaiser Permanente for Individuals and Families plan does not cover private duty nursing in the home,

hospital, or long-term care facility, except as required by law.

Reversal of voluntary sterilization

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

Routine physical examination

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

Surrogate pregnancy

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

Therapies

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

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

Travel and lodging

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

Vision care

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

Weight control programs and exercise programs

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

Dental Exclusions and Limitations

Adult dental services

This Kaiser Permanente for Individuals and Families plan does not cover dental services or supplies for Members age 19 and older, except as described under "Dental and Orthodontic Services" in the "Covered Benefits" section, or as required by law.

Pediatric dental services

This Kaiser Permanente for Individuals and Families plan does not cover dental services or supplies for Members up to age 19, except as described under "Dental and Orthodontic Services" in the "Covered Benefits" section or as described in the Pediatric Dental Services Amendment attached to this *EOC*.

Vision Exclusions and Limitations

Adult vision services

This Kaiser Permanente for Individuals and Families plan does not cover vision services for Members age 19 and older, except as described in this *EOC* under "Vision Services for Adult Members" in the "Covered Benefits" section, or as required by law.

Pediatric vision services

This Kaiser Permanente for Individuals and Families plan does not cover vision services for Members up to age 19, except as described in this *EOC* under "Vision Services for Pediatric Members" in the "Covered Benefits" section, or as required by law.

Coordination of Benefits

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

Reductions

Employer responsibility

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

Government agency responsibility

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

Injuries or illnesses alleged to be caused by other parties

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

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

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

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

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

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

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

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

Assisted Reproduction Agreement (pending regulatory approval)

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

By entering into an Assisted Reproduction Agreement, you automatically assign to us your right to receive payments that are payable to you or any other payee

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

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

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

You must send this information to:

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

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

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

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

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

U.S. Department of Veterans Affairs

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

Workers' compensation or employer's liability benefits

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

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

Post-Service Claims and Appeals

This "Post-Service Claims and Appeals" section explains how to file a claim for payment or reimbursement for

services that you have already received. Use the procedures in this section in the following situations:

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

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

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

Who May File

The following people may file claims:

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

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

Supporting Documents

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

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

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

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

Claims forms for all other services

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

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

Other supporting information

When you file a claim, include any information that clarifies or supports your position. For example, if you have paid for services, include any bills and receipts that support your claim. To request that we pay a Non–Plan Provider for services, include any bills from the Non–Plan Provider. If the Non–Plan Provider states that they

will file the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. When appropriate, we will request medical records from Plan Providers on your behalf. If you tell us that you have consulted with a Non–Plan Provider and are unable to provide copies of relevant medical records, we will contact the provider to request a copy of your relevant medical records. We will ask you to provide us a written authorization so that we can request your records.

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

Initial Claims

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

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

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

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

Mailing address to submit your claim to Kaiser Permanente:

For Northern California Service Area Members:
Kaiser Permanente
Claims Administration - NCAL
P.O. Box 12923
Oakland, CA 94604-2923

For Southern California Service Area Members:
Kaiser Permanente
Claims Administration - SCAL
P.O. Box 7004
Downey, CA 90242-7004

Call Member Services if you need help filing your claim.

Submitting a claim for all other services

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

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

Call Member Services if you need help filing your claim.

After we receive your claim

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

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

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

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

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

Appeals

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

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

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

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

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

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

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

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

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

If we initially denied your request, you must file your appeal within 180 days after the date you received our denial letter. You may send us information including comments, documents, and medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Send all additional information to the address or fax mentioned in your denial letter.

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

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

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

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

External Review

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

Additional Review

You may have a right to request review in state court if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review.

Dispute Resolution

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

Grievances

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

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

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

Who may file

The following people may file a grievance:

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

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

grievance. You must pay the cost of anyone you hire to represent or help you.

How to file

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

Standard Procedure

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

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

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

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

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

Call Member Services if you need help filing a grievance.

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

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

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

Urgent procedure

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

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

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

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

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

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

- You have received Emergency Services and Care but have not been discharged from a facility and your request involves admissions, continued stay, or other health care services
- You are undergoing a current course of treatment using a non-formulary Outpatient Prescription Drug and your grievance involves a request to refill a non-formulary Outpatient Prescription Drug

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

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

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

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

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

Additional information regarding pre-service requests for Medically Necessary services

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

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

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

Additional information regarding appeals of written denials for services that require prior authorization

You must file your appeal within 180 days after the date you received our denial letter.

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

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

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

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

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

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

Independent Review Organization for Non-Formulary Outpatient Prescription Drug Requests

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

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

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

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

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

Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll free at **1-800-464-4000** (TTY users call **711**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet website **www.dmhc.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review ("IMR")

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

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

- One of these situations applies to you:
  - you have a recommendation from a provider requesting Medically Necessary services

- ♦ you have received emergency or urgent medical services from a provider who determined the services to be Medically Necessary
- ♦ you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition

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

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

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

Experimental or investigational denials

If we deny services because they are Experimental Services or Investigational Services, we will send you our written explanation within three days after we received your request. We will explain why we denied the services and provide additional dispute resolution options. Also, we will provide information about your right to request Independent Medical Review if we had the following information when we made our decision:

- Your treating physician provided us a written statement that you have a Life-Threatening or Seriously Debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested
- If your treating physician is a Plan Physician, they recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying their recommendation
- You (or your Non–Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the physician in certifying their recommendation. We do not cover the services of the Non–Plan Provider

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

Office of Civil Rights Complaints

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

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

Additional Review

You may have a right to request review in state court if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review.

Binding Arbitration

For all claims subject to this "Binding Arbitration" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding

arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *EOC*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of arbitration

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

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

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

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

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

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

"Kaiser Permanente Parties" include:

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

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

Rules of Procedure

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

Initiating arbitration

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

Serving Demand for Arbitration

Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

For Northern California Service Area Members:
Kaiser Foundation Health Plan, Inc.
Legal Department, Professional & Public Liability
1 Kaiser Plaza, 19th Floor
Oakland, CA 94612

For Southern California Service Area Members:
Kaiser Foundation Health Plan, Inc.
Legal Department, Professional & Public Liability
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 Member Services.

Number of arbitrators

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

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

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

Payment of arbitrators' fees and expenses

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

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

Costs

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

General provisions

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

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

apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with another party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2028, your last minute of coverage was at 11:59 p.m. on December 31, 2027). You will be billed as a non-Member for any services you receive after your membership terminates, except for certain pediatric dental services described in a Pediatric Dental Services Amendment to this *EOC* (if applicable). If your plan has a Pediatric Dental Services Amendment, it will be attached to this *EOC*, and it will be listed in the *EOC's* Table of Contents. When your membership terminates, Health Plan and Plan Providers have no further liability or responsibility under this *EOC,* except as provided under "Payments after Termination" in this "Termination of Membership" section.

How You May Terminate Your Membership

If you are enrolled through Covered California

Contact Covered California or Health Plan for information about how to terminate your membership and the effective date of termination. You must provide notice to Covered California or Health Plan at least 14 days prior to the date you want your coverage to end.

If you are enrolled directly with Kaiser Permanente

You may terminate your membership by sending written notice, signed by the Subscriber, to the address below. If you are a Subscriber with enrolled Dependents, we will terminate the entire Family. You may choose to keep your children under 21 on a child-only account. It is important that you submit your termination notice as soon as you know that you want to terminate your coverage. Your membership will terminate at 11:59 p.m. on the day we receive your notice, or the date you indicate in your written notice to us, whichever is later. All amounts payable related to this *EOC*, including Premiums for the period prior to your termination date, continue to be due and payable in accord with the most recent invoice or notice you received. If you have questions, call Member Services.

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 23127
San Diego, CA 92193-3127

If you have Ancillary Coverage

If you have selected Ancillary Coverage provided under any other program, that plan's evidence of coverage cannot be terminated without terminating coverage under this *EOC*, unless the change is made during open enrollment or a special enrollment period.

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month (unless a different date is identified under "Eligibility as a Dependent" in the "Premiums, Eligibility, and Enrollment" section). For example, if you become ineligible on December 5, 2027, your termination date is January 1, 2028, and your last minute of coverage is at 11:59 p.m. on December 31, 2027.

Continuation of membership

If you lose eligibility as a Dependent and want to remain a Health Plan member, you might be able to enroll in one of our Kaiser Permanente for Individuals and Families plans as a subscriber with a qualifying life event or during Open Enrollment.

Go to **kp.org/specialenrollment** or call Member Services to learn more. For information about plans that

are available through Covered California, see "Covered California" below.

Covered California

U.S. citizens or legal residents of the U.S. can buy health care coverage from Covered California. This is California's health benefit exchange ("the Exchange"). You may apply for help to pay for premiums and copayments but only if you buy coverage through Covered California. This financial assistance may be available if you meet certain income guidelines. To learn more about coverage that is available through Covered California, visit **CoveredCA.com** or call Covered California at **1-800-300-1506** (TTY users call **711**).

Termination for Cause

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

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

After your first 24 months of individuals and families coverage, we may not terminate you for cause solely because you gave us incorrect or incomplete material information in your application for health coverage.

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 for Nonpayment of 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 Premiums" section. If you intend to terminate your membership, be sure to notify us as described under "How You May Terminate Your Membership" in this "Termination of Membership" 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.

If we do not receive advance payment of the premium tax credit ("APTC") on your behalf

Your Premium payment for the upcoming coverage month is due on the last day of the preceding month. If we do not receive Full Premium payment by the due date, we will send a notice of nonreceipt of payment to the Subscriber's address of record. You will have a 30-day grace period to pay the required Premiums before we terminate this *EOC* for nonpayment. The notice will state when the grace period begins and when the memberships of the Subscriber and all Dependents will terminate if the required Premiums are not paid. Your coverage will continue during this grace period. If we do not receive Full Premium payment by the end of the grace period, we will mail a termination notice to the Subscriber's address of record. After termination of your membership for nonpayment of Premiums, you are still responsible for paying all amounts due, including Premiums for the grace period.

If we receive APTC on your behalf

APTC is state or federal financial assistance available to eligible subscribers when enrolling in a Covered California health plan. If we receive APTC on your behalf, then you are responsible for paying the portion of the monthly Premiums that equals the Full Premiums minus the APTC that we receive on your behalf for that month. Your portion of the Premiums for the upcoming coverage month is due on the last day of the preceding month. If we do not receive your portion of the monthly Premiums on time, we will provide a three-month grace period.

We will send written notice stating when the grace period begins. The notice will explain when Premiums are due and when the memberships of the Subscriber and all Dependents will terminate if you do not pay your portion of all outstanding Premiums. If we do not receive your portion of all outstanding Premiums (including any Premiums for the grace period) by the end of the grace

period, we may terminate your membership. After termination of your membership for nonpayment of Premiums, you are still responsible for paying all amounts due, including Premiums for your first month of unpaid coverage and any other bills owed to Kaiser Permanente as described in the grace period notice.

Termination for Discontinuance of a Product or all Products

We may terminate your membership if we discontinue offering this product as permitted or required by law. If we continue to offer other individual (nongroup) products, we may terminate your membership under this product by sending you written notice at least 90 days before the termination date. You will be able to enroll in any other product we are then offering in the individual (nongroup) market if you meet all eligibility requirements. Under the Affordable Care Act, individual plan coverage is available without medical review. The premiums and coverage under the other individual plan may differ from those under this *EOC*. If we discontinue offering all individual (nongroup) products, we may terminate your membership by sending you written notice at least 180 days before the termination date.

Payments after Termination

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

- Within 30 days, refund any amounts we owe for Premiums you paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Dispute Resolution" section

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

Rescission of Membership

During your first 24 months of coverage, we may rescind your membership after it becomes effective (completely cancel your membership so that no membership ever existed) if we determine you or anyone seeking membership on your behalf did any of the following before your membership became effective:

- Performed an act, practice, or omission that constitutes fraud in connection with your enrollment or enrollment application
- Made an intentional misrepresentation of material fact in connection with your enrollment or enrollment application, such as intentionally omitting a material fact
- Intentionally failed to inform us of material changes to the information in your enrollment application

We will send written notice to the Subscriber at least 30 days before we rescind your membership, but the rescission will completely cancel your membership so that no membership ever existed. Our notice will explain the basis for our decision and how you can appeal this decision. If your coverage is rescinded, you must pay full Charges for any services we covered. We will refund all applicable Premium except that we may subtract any amounts you owe us. You will be ineligible to re-apply for membership until the next open enrollment period.

After your first 24 months of coverage, we may not rescind your membership if you or someone on your behalf gave us incorrect or incomplete material information, whether or not you or someone on your behalf willfully intended to give us that information.

Appealing Membership Termination or Rescission

If you believe that we have terminated or rescinded your membership improperly, you may file a grievance to appeal the decision. Refer to the "Grievances" in the "Dispute Resolution" section for information on how to file a grievance.

State Review of Membership Termination

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

Miscellaneous Provisions

Administration of this *EOC*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this *EOC*.

Advance Health Care Directives

The California Health Care Decision Law offers several ways for you to control the kind of health care you will receive if you become very ill or unconscious, including the following:

- A *Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your own views on life support and other treatments
- *Individual health care instructions* let you express your wishes about receiving life support and other treatment. You can express these wishes to your doctor and have them documented in your medical chart, or you can put them in writing and have that included in your medical chart

For more information about Advance Health Care Directives, refer to our website at **kp.org**, call Member Services, or contact the California Attorney General's Office.

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *EOC*.

Assignment

You may not assign this *EOC* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

Attorney and Advocate Fees and Expenses

In any dispute between a Member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses.

Catastrophic Events

We will make a good faith effort to provide or arrange for Covered Benefits upon the occurrence of circumstances or an event not within Health Plan's reasonable control that delay or render impractical the provision of services under this *EOC*, such as a natural disaster (for example, earthquake, wildfire, hurricane or tornado), epidemic, pandemic, terrorism, war, riot, civil insurrection, government acts, changes in applicable law, disability of entities providing services to Health Plan, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor dispute ("Catastrophic Event") in order to minimize the effects of the Catastrophic Event taking into account its impact on the provision of Covered Benefits. Such effort may include reasonably and prudently processing requests for Covered Benefits in a manner that may be inconsistent with this *EOC*. Under these circumstances, if you have an Emergency Medical Condition or Psychiatric Emergency Medical Condition, call 911 or go to the nearest emergency department as described under "Emergency Services and Care" in the "How to Obtain Covered Benefits" section, and we will provide coverage and reimbursement as described in that section.

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *EOC* and we have the discretionary authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*. We may use medical experts to help us review claims. If coverage under this *EOC* is subject to the Employee Retirement Income Security Act ("ERISA") claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *EOC*.

EOC Binding on Members

By electing coverage or accepting benefits under this *EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *EOC*.

Governing Law

Except as preempted by federal law, this *EOC* will be governed in accord with California law and any provision that is required to be in this *EOC* by state or federal law shall bind Members and Health Plan whether or not set forth in this *EOC*.

Members' Rights and Responsibilities

As a Member, you have a right to:

- Receive information about your rights and responsibilities.

- Receive information about your health plan, the services your health plan offers you, and the Health Care Providers available to care for you.
- Make recommendations regarding the health plan's member rights and responsibilities policy.
- Receive information about all health care services available to you, including a clear explanation of how to obtain them and whether the health plan may impose certain limitations on those services.
- Know the costs for your care, and whether your deductible or out-of-pocket maximum have been met.
- Choose a Health Care Provider in your health plan's network, and change to another doctor in your health plan's network if you are not satisfied.
- Receive timely and geographically accessible health care.
- Have a timely appointment with a Health Care Provider in your health plan's network, including one with a specialist.
- Have an appointment with a Health Care Provider outside of your health plan's network when your health plan cannot provide timely access to care with an in-network Health Care Provider.
- Certain accommodations for your disability, including:
  - ♦ equal access to medical services, which includes accessible examination rooms and medical equipment at a Health Care Provider's office or facility.
  - ♦ full and equal access, as other members of the public, to medical facilities.
  - ♦ extra time for visits if you need it.
  - ♦ taking your service animal into exam rooms with you.
- Purchase health insurance or determine Medi-Cal eligibility through the California Health Benefit Exchange, Covered California.
- Receive considerate and courteous care and be treated with respect and dignity.
- Receive culturally competent care, including but not limited to:
  - ♦ Trans-Inclusive Health Care, which includes all Medically Necessary services to treat gender dysphoria or intersex conditions.
  - ♦ to be addressed by your preferred name and pronoun.
- Receive from your Health Care Provider, upon request, all appropriate information regarding your health problem or medical condition, treatment plan, and any proposed appropriate or Medically Necessary treatment alternatives. This information includes available expected outcomes information, regardless of cost or benefit coverage, so you can make an informed decision before you receive treatment.
- Participate with your Health Care Providers in making decisions about your health care, including giving informed consent when you receive treatment. To the extent permitted by law, you also have the right to refuse treatment.
- A discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Receive health care coverage even if you have a pre-existing condition.
- Receive Medically Necessary treatment of a Mental Health or Substance Use Disorder.
- Receive certain preventive health services, including many without a co-pay, co-insurance, or deductible.
- Have no annual or lifetime dollar limits on basic health care services.
- Keep eligible dependent(s) on your health plan.
- Be notified of an unreasonable rate increase or change, as applicable.
- Protection from illegal balance billing by a Health Care Provider.
- Request from your health plan a second opinion by an Appropriately Qualified Health Care Provider.
- Expect your health plan to keep your personal health information private by following its privacy policies, and state and federal laws.
- Ask most Health Care Providers for information regarding who has received your personal health information.
- Ask your health plan or your doctor to contact you only in certain ways or at certain locations.
- Have your medical information related to sensitive services protected.
- Get a copy of your records and add your own notes. You may ask your doctor or health plan to change information about you in your medical records if it is not correct or complete. Your doctor or health plan may deny your request. If this happens, you may add a statement to your file explaining the information.
- Have an interpreter who speaks your language at all points of contact when you receive health care services.

- Have an interpreter provided at no cost to you.
- Receive written materials in your preferred language where required by law.
- Have health information provided in a usable format if you are blind, deaf, or have low vision.
- Request continuity of care if your Health Care Provider or medical group leaves your health plan or you are a new health plan member.
- Have an Advance Health Care Directive.
- Be fully informed about your health plan's grievances procedure and understand how to use it without fear of interruption to your health care.
- File a complaint, grievance, or appeal in your preferred language about:
  - your health plan or Health Care Provider.
  - any care you receive, or access to care you seek.
  - any covered service or benefit decision that your health plan makes.
  - any improper charges or bills for care.
  - any allegations of discrimination on the basis of gender identity or gender expression, or for improper denials, delays, or modifications of Trans-Inclusive Health Care, including Medically Necessary services to treat gender dysphoria or intersex conditions.
  - not meeting your language needs.
- Know why your health plan denies a service or treatment.
- Contact the Department of Managed Health Care if you are having difficulty accessing health care services or have questions about your health plan.
- To ask for an Independent Medical Review if your health plan denied, modified, or delayed a health care service.

As a Member, you have the responsibility to:

- Treat all Health Care Providers, Health Care Provider staff, and health plan staff with respect and dignity.
- Share the information needed with your health plan and Health Care Providers, to the extent possible, to help you get appropriate care.
- Participate in developing mutually agreed-upon treatment goals with your Health Care Providers and follow the treatment plans and instructions to the degree possible.
- To the extent possible, keep all scheduled appointments, and call your Health Care Provider if you may be late or need to cancel.
- Refrain from submitting false, fraudulent, or misleading claims or information to your health plan or Health Care Providers.
- Notify your health plan if you have any changes to your name, address, or family members covered under your health plan.
- Timely pay any Premiums, Cost Share, and charges for non-covered services.
- Notify your health plan as soon as reasonably possible if you are billed inappropriately.

No Waiver

Our failure to enforce any provision of this *EOC* will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Notices Regarding Your Coverage

If enrolled through Health Plan

Our notices to you will be sent to the most recent address we have for the Subscriber, except that if the Subscriber has chosen to receive these membership agreement and evidence of coverage documents online we will notify the Subscriber at the most recent email address we have for the Subscriber when notices related to amendment of this *EOC* are posted on our website at **kp.org**. The Subscriber is responsible for notifying us of any change in address. Subscribers who move (or change their email address if the Subscriber has chosen to receive these membership agreement and evidence of coverage documents on our website) should call Member Services as soon as possible to give us their new address. If a Member does not reside with the Subscriber, or needs to have confidential information sent to an address other than the Subscriber's address, they should call Member Services to discuss alternate delivery options.

If enrolled through Covered California

Covered California's notices to you will be sent to the most recent address Covered California has for the Subscriber. The Subscriber is responsible for notifying Covered California of any change in address. Subscribers who move should call Covered California as soon as possible to update their address. If a Member does not reside with the Subscriber, or needs to have confidential information sent to an address other than the Subscriber's address, they should contact Covered California to discuss alternate delivery options.

Overpayment Recovery

We may recover any overpayment we make for services from anyone who receives such an overpayment or from any person or organization obligated to pay for the services.

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information. Your protected health information is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information.

You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means. You may request confidential communication by completing a confidential communication request form, which is available on **kp.org** under "Request for confidential communications forms." Your request for confidential communication will be valid until you submit a revocation or a new request for confidential communication. If you have questions, call Member Services.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of services. We are sometimes required by law to give protected health information to others, such as government agencies.

We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. OUR *NOTICE OF PRIVACY PRACTICES*, WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY PRACTICES AND YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION, IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. To request a copy, call Member Services. You can also find the notice at a Plan Facility or on our website at **kp.org**.

Public Policy Participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. If you would like to provide input about Health Plan public policy for consideration by the Board, send written comments to:

Kaiser Foundation Health Plan, Inc.
Office of Board and Corporate Governance Services
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Value-Added Services

In addition to the Covered Benefits that we describe in this *EOC*, we may make available a variety of extra services. Extra services are not covered by your plan. They are intended to give you more options for a healthy lifestyle. Examples may include:

- Certain health education classes not covered by your plan
- Certain health education publications
- Discounts for fitness club memberships
- Wellness programs

Some of these extra services are available to all Members. Others may be available only to Members enrolled through certain groups or plans. To take advantage of these services, you may need to:

- Show your Health Plan ID card
- Pay the fee, if any

- Participate in any required activity

Because these services are not covered by your plan, any fees you pay will not count toward any coverage calculations, such as your Plan Deductible or Plan Out-of-Pocket Maximum.

We do not endorse or make any representations regarding the quality or medical efficacy of any extra service, or the financial integrity of the companies offering them. If you encounter any issues regarding extra services, you can contact the company providing the services. You may also call Member Services, and a representative may try to assist in getting the issue resolved. Additionally, you have a right to file a grievance as described under "Grievances" in the "Dispute Resolution" section.

Helpful Information

How to Obtain this *EOC* in Other Formats

You can request a copy of this *EOC* in an alternate format (Braille, audio, electronic text file, or large print) by calling Member Services.

Provider Directory

Refer to the Provider Directory for your Service Area for the following information:

- A directory of physicians, licensed health care professionals, and facilities in your Service Area
- A list of Plan Physicians
- The location of Plan Facilities and the types of Covered Benefits that are available from each facility
- Hours of operation
- Appointments and advice phone numbers

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

Online Tools and Resources

Here are some tools and resources available on our website at **kp.org**:

- How to use our services and make appointments
- Tools you can use to email your doctor's office, view test results, refill prescriptions, and schedule routine appointments
- Health education resources
- Preventive care guidelines
- Member rights and responsibilities

You can also access tools and resources using the KP app on your smartphone or other mobile device.

Document Delivery Preferences

Many Health Plan documents are available electronically, such as bills, statements, and notices. If you prefer to get documents in electronic format, go to **kp.org** or call Member Services. You can change delivery preference at any time. To get a copy of a specific Heath Plan document in printed format, call Member Services.

How to Reach Us

Appointments

If you need to make an appointment, call us or visit our website:

Call The appointment phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call Member Services)

Website **kp.org** for routine (non-urgent) appointments with your personal Plan Physician or another Primary Care Physician

Not sure what kind of care you need?

If you need advice on whether to get medical care, or how and when to get care, we have licensed health care professionals available to assist you by phone 24 hours a day, seven days a week:

Call The appointment or advice phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call Member Services)

Member Services

If you have questions or concerns about your coverage, how to obtain services, or the facilities where you can receive care, you can reach us in the following ways:

Call **1-800-464-4000** (English and more than 150 languages using interpreter services)
1-800-788-0616 (Spanish)
1-800-757-7585 (Chinese dialects)
TTY users call **711**

24 hours a day, seven days a week (closed holidays)

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

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

Website kp.org

If you have questions about enrollment or eligibility in coverage offered by Covered California, contact Covered California directly. Refer to "How to Reach Covered California" below in this "Helpful Information" section.

Estimates, bills, and statements

For the following concerns, call us at the number below:

- If you have questions about a bill
- To find out how much you have paid toward your Plan Deductible (if applicable) or Plan Out-of-Pocket Maximum
- To get an estimate of Charges for services that are subject to the Plan Deductible (if applicable)

Call **1-800-390-3507** (TTY users call **711**)

Monday through Friday 6 a.m. to 5 p.m.

Website kp.org

Away from Home Travel Line

If you have questions about your coverage when you are away from home:

Call **1-951-268-3900**

24 hours a day, seven days a week (closed holidays)

Website kp.org/travel

Authorization for Post-Stabilization Care

To request prior authorization for Post-Stabilization Care as described under "Emergency Services and Care" in the "How to Obtain Covered Benefits" section:

Call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card (TTY users call **711**)

24 hours a day, seven days a week

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

If you need a claim form to request payment or reimbursement for services described under "Emergency Services and Care and Urgent Care" or "Ambulance Services" in the "Covered Benefits" section, or COVID-19 services under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Pharmacy Services," and "Preventive Services" in the "Covered Benefits" section, or if you need help completing the form, you can reach us by calling or by visiting our website.

Call **1-800-464-4000** (TTY users call **711**)

24 hours a day, seven days a week (closed holidays)

Website kp.org

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

If you need to submit a completed claim form for services described under "Emergency Services and Care and Urgent Care" or "Ambulance Services" in the "Covered Benefits" section, or COVID-19 services under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services," "Outpatient Pharmacy Services," and "Preventive Services" in the "Covered Benefits" section, or if you need to submit other information that we request about your claim, send it to our Claims Department:

Write *For Northern California Service Area Members:*

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

For Southern California Service Area Members:

Kaiser Permanente
Claims Administration - SCAL
P.O. Box 7004
Downey, CA 90242-7004

Text telephone access ("TTY")

If you use a text telephone device ("TTY," also known as "TDD") to communicate by phone, you can use the California Relay Service by calling **711**.

Interpreter services

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

How to Reach Covered California

If you have questions about enrollment or eligibility in coverage offered by Covered California, visit Covered California's website or call the Covered California Service Center:

Call **1-800-300-1506**
1-888-889-4500 (TTY)

Website **CoveredCA.com**

Payment Responsibility

This "Payment Responsibility" section briefly explains who is responsible for payments related to the health care coverage described in this *EOC*. Payment responsibility is more fully described in other sections of the *EOC* as described below:

- The Subscriber is responsible for paying Premiums (refer to "Premiums" in the "Premiums, Eligibility, and Enrollment" section)
- You are responsible for paying your Cost Share for Covered Benefits (refer to the "Cost Share Summary" section)
- If you receive Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, or COVID-19 services from a Non–Plan Provider, or if you receive emergency ambulance services, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us (refer to "Emergency Services and Care and Urgent Care" in the "Covered Benefits" section)
- If you receive services from Non–Plan Providers that we did not authorize (other than Emergency Services and Care, Post-Stabilization Care, Out-of-Area Urgent Care, emergency ambulance services, or COVID-19 services) and you want us to pay for the care, you must submit a grievance (refer to "Grievances" in the "Dispute Resolution" section)
- If you have Medicare, we will coordinate benefits with the other coverage (refer to "Coordination of Benefits" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- In some situations, you or another party may be responsible for reimbursing us for Covered Benefits (refer to "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- You must pay the full price for non-covered services

Pediatric Dental Services Amendment

We cover certain dental services for Eligible Pediatric Enrollees through Delta Dental of California ("Delta Dental"). Please read the following information so that you will know how to obtain dental services. You must obtain dental Benefits from (or be referred for Specialist Services by) your assigned Contract Dentist.

ADDITIONAL INFORMATION ABOUT YOUR PEDIATRIC DENTAL BENEFITS IS AVAILABLE BY CALLING THE DELTA DENTAL CUSTOMER CARE AT 800-589-4618, 5 A.M. - 6 P.M., PACIFIC TIME, MONDAY THROUGH FRIDAY.

Delta Dental
P.O. Box 1803
Alpharetta, GA 30023-1803

IMPORTANT: If you opt to receive dental services that are not covered Benefits under this Program, a Contract Dentist may charge you their 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 Delta Dental Customer Care at 800-589-4618. To fully understand your coverage, you may wish to carefully review this Amendment.

Introduction

This document amends your Kaiser Foundation Health Plan, Inc. (Health Plan) *EOC* to add coverage for pediatric dental services as described in this Pediatric Dental Services Amendment ("Amendment"). All provisions of the *EOC* apply to coverage described in this document except for the following sections:

- "How to Obtain Covered Benefits" (except that the completion of services information in the "Getting a Referral" section does apply to coverage described in this document)
- "Plan Facilities"
- "Covered Benefits," except that the information under "Plan Out-of-Pocket Maximum" in the "Covered Benefits" section does apply
- "Post-Service Claims and Appeals"
- "Dispute Resolution"

These pediatric dental Benefits are for Eligible Pediatric Enrollees.

The DeltaCare USA Program provides essential pediatric dental care benefits. Benefits are accessed through the DeltaCare USA Individual Network, a convenient network of Contract Dentists and established dental professionals, who are screened to ensure that standards of quality, access and safety are maintained.

Health Plan contracts with Delta Dental to make the DeltaCare USA Program and its DeltaCare USA Individual Network available to you. You are assigned a Contract Dentist from the DeltaCare USA Individual Network. You can obtain covered Benefits from your assigned Contract Dentist without a referral from a Plan Physician. When you visit your assigned Contract Dentist your Cost Share is due, and you pay only the applicable Cost Share of Benefits up to the Plan Out-of-Pocket Maximum. See the "Cost Share Summary" section of your *EOC* for information about your Plan Out-of-Pocket Maximum.

Definitions

In addition to the terms defined in the "Definitions" section of your Health Plan *EOC* the following terms, when capitalized and used in any part of this Amendment have the following meanings:

Authorization means the process by which Delta Dental determines if a procedure or treatment is a referable Benefit under this Program.

Benefits mean those covered pediatric dental services provided as described in this Amendment.

Contract Dentist means a DeltaCare USA Dentist who provides services in general dentistry and who has agreed to provide Benefits to Enrollees under this Program.

Contract Orthodontist means a DeltaCare USA Dentist who specializes in orthodontics and who has agreed to provide Benefits to Enrollees under this Program, which covers Medically Necessary orthodontics. Enrollees must obtain a referral from their Contract Dentist to obtain services from a Contract Orthodontist.

Contract Specialist means a DeltaCare USA Dentist who provides Specialist Services and who has agreed to provide Benefits to Enrollees under this Program. Enrollees must obtain a referral from their Contract Dentist to obtain services from a Contract Specialist.

Delta Dental Service Area means all geographic areas in the state of California in which Delta Dental is licensed as a specialized health care service plan.

Dentist means a duly licensed dentist legally entitled to practice dentistry at the time and in the state or jurisdiction in which services are performed.

Department of Managed Health Care is a department of the California Health and Human Services Agency which has charge of regulating specialized health care service plans. Also referred to as the "Department" or "DMHC."

Eligible Pediatric Enrollee means a person eligible for dental Benefits under this Amendment. Eligible Pediatric Enrollees are children from birth through the end of the month in which the child turns 19 who meet the eligibility requirements in your Health Plan *EOC*.

Emergency Dental Condition means dental symptoms and/or pain that are so severe that a reasonable person would believe that, without immediate attention by a Dentist, they could reasonably be expected to result in any of the following:

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

Emergency Dental Service means a dental screening, examination and evaluation by a Dentist, or, to the extent permitted by applicable law, by other appropriate licensed persons under the supervision of a Dentist, to determine if an Emergency Dental Condition exists and, if it does, the care, treatment, and surgery, if within the scope of that person's license, necessary to relieve or eliminate the Emergency Dental Condition, within the capability of the facility.

Optional means any alternative procedure presented by the Contract Dentist that satisfies the same dental need as a covered procedure but is chosen by the Enrollee and is subject to the limitations and exclusions described in the Schedules attached to this Amendment.

Out-of-Network means treatment by a Dentist who has not signed an agreement with Delta Dental to provide Benefits to Enrollees under the terms of this Amendment.

Pediatric Enrollee means an Eligible Pediatric Enrollee enrolled to receive Benefits; may also be referred to as "Enrollee."

Procedure Code means the Current Dental Terminology® ("CDT") number assigned to a Single Procedure by the American Dental Association.

Program means the set of pediatric dental Benefits provided under this Amendment to your *EOC*.

Single Procedure means a dental procedure that is assigned a separate Procedure Code.

Special Health Care Need means 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 facility because of a physical disability, and 2) the Enrollee's inability to comply with their Contract Dentist's instructions during examination or treatment because of physical disability or mental incapacity.

Specialist Service means 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.

Teledentistry means the delivery of dental services through telehealth or telecommunications that may include the use of real-time encounter; live video (synchronous) or information stored and forwarded for subsequent review (asynchronous).

Treatment in Progress means any Single Procedure that has been started while the Pediatric 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 this Program. 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.

Urgent Dental Services means Medically Necessary services for a condition that requires prompt dental attention but is not an Emergency Dental Condition.

How to Obtain Pediatric Dental Services

Upon enrollment, the Enrollee will be assigned to a Contract Dentist facility. The Enrollee may request changes to their assigned Contract Dentist facility by contacting Delta Dental Customer Care at **800-589-4618**. A list of Contract Dentists is available to all Enrollees at deltadentalins.com. Enrollees in the same family may collectively select no more than three Contract Dentist facilities. The change must be requested prior to the 15th of the month to become effective on the first day of the following month.

Delta Dental 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 withdraws from the DeltaCare USA Individual Network, or 3) an assigned facility requests, for good cause, that the Enrollee be re-assigned to another Contract Dentist facility.

All Treatment in Progress must be completed before you change to another Contract Dentist facility. EACH ENROLLEE MUST GO TO THEIR ASSIGNED CONTRACT DENTIST TO OBTAIN COVERED SERVICES.

All covered services must be performed at the Enrollee's assigned Contract Dentist facility. Specialist Services obtained from a Contract Orthodontist or Contract Specialist must be referred by the Enrollee's Contact Dentist. With the exception of Emergency Dental Services, Urgent Dental Services, and authorized Specialist Services, this Program does not pay for services received by Out-of-Network Dentists. All authorized Specialist Service claims will be paid by Delta Dental, less any applicable Cost Share. Any other treatment is not covered under this Program.

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 an Enrollee is assigned to a dental school clinic for Specialist Services, those services may be provided by a Dentist, a dental student, a clinician or a dental instructor.

If your assigned Contract Dentist terminates participation in the DeltaCare USA Individual Network, that Contract Dentist will complete all Treatment in Progress. If, for any reason, the Contract Dentist is unable to complete treatment, Delta Dental will make reasonable and appropriate provisions for the completion of such treatment by another Contract Dentist.

Delta Dental will give you reasonable advance written notice if you will be materially or adversely affected by the termination, breach of contract, or inability of a Contract Dentist to perform services.

Benefits, Limitations and Exclusions

This Program provides the Benefits described in *Schedule A* subject to the limitations and exclusions described in *Schedule B*. With the exception of Emergency Dental Services, Urgent Dental Services, and authorized Specialist Services, Benefits are only available in the state of California. The services are performed as deemed appropriate by your assigned Contract Dentist.

Continuity of Care

If you are a current Enrollee, you may have the right to obtain completion of care with your terminated Contract Dentist for specified dental conditions. If you are a new Enrollee, you may have the right to completion of care with your Out-of-Network Dentist for specified dental conditions. You must make a specific request for this completion of care Benefit. To make a request, contact Delta Dental's Customer Care 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 Program 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 Dental Services

Emergency Dental Services are used for palliative relief, controlling of dental pain, and/or stabilizing the Enrollee's condition. The Enrollee's assigned Contract Dentist facility maintains a 24-hour emergency dental services system, 7 days a week. If the Enrollee is experiencing an Emergency Dental Condition, they can call 911 (where available) or obtain Emergency Dental Services from any Dentist without a referral.

After Emergency Dental Services are provided, further non-emergency treatment is usually needed. Non-emergency treatment must be obtained at the Enrollee's assigned Contract Dentist facility.

The Enrollee is responsible for any Cost Share for Emergency Dental Services received. Non-covered procedures will be the Enrollee's financial responsibility and will not be paid by this Program.

Urgent Dental Services

Inside the Delta Dental Service Area

An Urgent Dental Service requires prompt dental attention but it is not an Emergency Dental Condition. If an Enrollee thinks that they may need Urgent Dental Services, the Enrollee can call their Contract Dentist during normal business hours or after hours.

Outside the Delta Dental Service Area

If an Enrollee needs Urgent Dental Services due to an unforeseen dental condition or injury, this Program covers Medically Necessary dental services when prompt attention is required from an Out-of-Network Dentist, if all of the following are true:

- The Enrollee receives the Urgent Dental Services from an Out-of-Network Dentist while temporarily outside the Delta Dental Service Area
- A reasonable person would have believed that the Enrollee's health would seriously deteriorate if they delayed treatment until they returned to the Delta Dental Service Area

Enrollees do not need prior Authorization from Delta Dental to receive Urgent Dental Services outside the Delta Dental Service Area. Any Urgent Dental Services an Enrollee receives from Out-of-Network Dentists outside the Delta Dental Service Area are covered by this Program if the Benefits would have been covered if the Enrollee had received them from Contract Dentists.

We do not cover follow-up care from Out-of-Network Dentists after the Enrollee no longer needs Urgent Dental Services. To obtain follow-up care from a Contract Dentist, the Enrollee can call their assigned Contract Dentist.

The Enrollee is responsible for any Cost Share for Urgent Dental Services received.

Timely Access to Care

Contract Dentists, Contract Orthodontists and Contract Specialists have agreed waiting times to Enrollees for appointments for care which will never be greater than the following timeframes:

- for emergency care, 24 hours a day, 7 days a week
- for any urgent care, 72 hours for appointments consistent with the Enrollee's individual needs
- for any non-urgent care, 36 business days
- for any preventive services, 40 business days

During non-business hours, the Enrollee will have access to their Contract Dentist's answering machine, answering service, cell phone or pager for guidance on what to do and whom to contact for Urgent Dental Services or if the Enrollee is calling due to an Emergency Dental Condition including while outside the Delta Dental Service Area.

If the Enrollee calls Delta Dental's Customer Care, a representative will answer the phone within 10 minutes during normal business hours.

Language Assistance Services

Delta Dental offers qualified interpretation services to limited-English proficient Enrollees at no cost to the Enrollee, at all points of contact, in any modern language including when an Enrollee is accompanied by a family member or friend who can provide language interpretation services.

If you need language interpretation services, materials translated into your preferred language or into an alternative format, please call Delta Dental Customer Care at **800-589-4618 (TTY: 711)**. You may also visit the provider directory on our website which includes self-reported languages by DeltaCare USA Dentists.

Specialist Services

Specialist Services for oral surgery, endodontics, orthodontics, periodontics or pediatric dentistry must be: 1) referred by your assigned Contract Dentist, and 2) authorized by Delta Dental. You pay the specified Cost Share. (Refer to *Schedule A, Description of Benefits and Cost Share for Pediatric Enrollees* and *Schedule B, Limitations and Exclusions of Benefits.*)

If the services of a Contract Orthodontist are needed, please refer to Orthodontics in *Schedule A, Description of Benefits and Cost Share for Pediatric Enrollees* and *Schedule B, Limitations and Exclusions of Benefits* to determine which procedures are covered under this Program.

If you require Specialist Services and a Contract Specialist or Contract Orthodontist is not within 35 miles of your home address to provide these services, your assigned Contract Dentist must receive Authorization from Delta Dental to refer you to an Out-of-Network specialist or Out-of-Network orthodontist to provide these Specialist Services. Specialist Services performed by an Out-of-Network specialist or Out-of-Network orthodontist that are not authorized by Delta Dental will not be covered.

Claims for Reimbursement

Claims for covered Emergency Dental Services, Urgent Dental Services, and authorized Specialist Services should be sent to Delta Dental 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. All claims must be received within one (1) year of the treatment date. The address for claims submission is: Delta Dental, Claims Department, P.O. Box 1810, Alpharetta, GA 30023-1810.

Cost Share and Other Charges

You are required to pay any Cost Share listed in *Schedule A*. Your Cost Share is paid directly to the Dentist who provides treatment. Charges for visits after normal visiting hours are listed in *Schedule A*.

In the event that Delta Dental fails to pay a Contract Dentist, you will not be liable to that Dentist for any sums owed by Delta Dental. By statute, the DeltaCare USA Dentist agreement contains a provision prohibiting a Contract Dentist from charging an Enrollee for any sums owed by Delta Dental. Except for the provisions in the "Emergency Dental Services" section, 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 the "Emergency Dental Services" and "Specialist Services" sections.

Second Opinion

You may request a second opinion if you disagree with or question the diagnosis and/or treatment plan determination made by your Contract Dentist. You may also be requested to 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 the Enrollee's condition. Requests involving an imminent and serious threat to the Enrollee's health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or a lack of timeliness that would be detrimental to the Enrollee's ability to regain maximum function, 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 the Delta Dental Customer Care at **800-589-4618** or write to Delta Dental at P.O. Box 1810, Alpharetta, GA 30023.

Second opinions will be provided at another Contract Dentist's facility, unless otherwise authorized by Delta Dental. A second opinion by an Out-of-Network Dentist will be authorized if an appropriately qualified Contract Dentist is not available. Only second opinions which have been approved or authorized by Delta Dental will be paid. You will be sent a written notification if your request for a second opinion is not authorized. If you disagree with this determination, you may file a grievance with Delta Dental. Refer to the "Enrollee Complaint Procedure" section for more information.

Special Health Care Needs

If an Enrollee believes they have a Special Health Care Need, the Enrollee should contact Delta Dental's Customer Care at **800-589-4618**. Delta Dental will confirm that a Special Health Care Need exists and what arrangements can be made to assist the Enrollee in obtaining such Benefits.

Delta Dental will not be responsible for the failure of any Contract Dentist to comply with any law or regulation concerning structural office requirements that apply to a Dentist treating persons with Special Health Care Needs.

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 Care at 800-589-4618.

Dentist Compensation

A Contract Dentist is compensated by Delta Dental through monthly capitation (an amount based on the number of Enrollees assigned to the Contract Dentist), and by Enrollees through required Cost Share for treatment received. A Contract Specialist is compensated by Delta Dental through an agreed-upon amount for each covered procedure, less the applicable Cost Share paid by the Enrollee. In no event does Delta Dental pay a Contract Dentist or a Contract Specialist any incentive as an inducement to deny, reduce, limit or delay any appropriate treatment.

You may obtain further information concerning Dentist compensation by calling Delta Dental at **800-589-4618**.

Processing Policies

The dental care guidelines for this Program explain to Contract Dentists what services are covered under this Amendment. Contract Dentists, Contract Orthodontists, and Contract Specialists will use their professional judgment to determine which services are appropriate for the Enrollee. Services performed by the Contract Dentist, Contract Orthodontist, and Contract Specialist that fall under the scope of Benefits of this Program are provided, subject to any Cost Share. 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 Contract Specialist. An Enrollee may contact Delta Dental's Customer Care at **800-589-4618** for information about this Program's dental care guidelines.

Teledentistry Services

Teledentistry services are when a Dentist delivers dental services through telehealth or telecommunications to diagnose dental issues, offer dental care advice or determine appropriate dental treatment. It can be a convenient alternative option to an in-person dental appointment.

There are two types of Teledentistry services:

- **Synchronous** is real-time interaction such as a video call with Your Contract Dentist
- **Asynchronous** is when a video or photo of Your dental issue is sent to Your Contract Dentist and a reply is sent later

Delta Dental covers Teledentistry services at the diagnostic oral evaluation cost share amount shown in *Schedule A*, subject to the limitations and exclusions in *Schedule B*. A Teledentistry appointment is covered on the same basis and to the same extent that the Benefit is covered through in-person diagnosis, consultation or treatment and is inclusive in the overall patient management care and not a separately payable service.

Please note that not all Contract Dentists offer Teledentistry services and that not all dental conditions can be treated through Teledentistry visits. Delta Dental recommends that the Enrollee contact their Contract Dentist and Delta Dental Customer Care for additional information.

If the Enrollee is experiencing a life-threatening emergency, they should immediately call **911**.

Coordination of Benefits

Coordination of benefits means the method by which we pay for dental Benefits when you are covered by another dental plan. The dental Benefits under this Amendment will be primary to any other dental coverage purchased by the Enrollee. This means the dental provider will send any dental claims to Delta Dental first for payment under the dental Benefits covered in this Amendment.

Enrollee Complaint Procedure

Complaints regarding dental services:

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 a 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 Delta Dental's Customer Care at **800-589-4618 (TTY: 711)**, complete and submit a **DeltaCare USA Enrollee Grievance Form** online or mail the complaint to:

Delta Dental of California
Quality Management Department
P.O. Box 1860
Alpharetta, GA 30023-1860

Written communication must include: 1) the Pediatric Enrollee's name, address, telephone number and ID number and 2) the Dentist's name and facility location.

"Grievance" means a written or oral expression of dissatisfaction regarding Delta Dental and/or your dental 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 Delta Dental 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 five calendar days of the receipt of any complaint, the quality management coordinator will forward to you a written acknowledgment of the complaint which will include the date of receipt and contact information. 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 calendar days of receipt of a complaint. If the complaint involves an Emergency Dental Condition, Delta Dental will provide the Enrollee written notification regarding the disposition or pending status of the grievance within three days.

The Department is responsible for regulating health care service plans. If you have a grievance against Delta Dental, you should first telephone Delta Dental at **1-800-589-4618** and use Delta Dental's 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 Dental Condition, a grievance that has not been satisfactorily resolved by Delta Dental, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

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 180 calendar 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 this Amendment, 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.

Within five calendar days of the receipt of any complaint, the quality management coordinator will forward to you a written acknowledgment of the complaint which will include the date of receipt and contact information. Certain complaints may require that you be referred to a Dentist for clinical evaluation of the dental services provided. Delta Dental will forward to you a determination, in writing, within 30 calendar days of receipt of your complaint.

Complaints regarding all other issues:

If you have any other type of complaint or grievance, you can file a grievance with Health Plan. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about services you received. You may submit your grievance orally or in writing to Health Plan as described in the "Dispute Resolution" section of your *EOC*. If your complaint involves the termination of coverage, you may contact the Department immediately.

Independent Medical Review ("IMR"):

You may also be eligible for an IMR. If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by Delta Dental related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The Department's Internet website **(www.dmhc.ca.gov)** has complaint forms, IMR application forms and instructions online.

SCHEDULE A - Description of Benefits and Cost Share for Pediatric Enrollees

The Benefits shown below are performed as needed and deemed appropriate by the attending Contract Dentist subject to the limitations and exclusions of the Program. 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 Program and is not to be interpreted as Current Dental Terminology ("CDT"), CDT-2026 Procedure Codes, descriptors or nomenclature which is under copyright by the American Dental Association ("ADA"). The ADA 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.

D0100–D0999 I. DIAGNOSTIC

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations for Pediatric Enrollees
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*
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 per 3 months, not to exceed 12 per 12-month period*
D0171	Re-evaluation - post-operative office visit	No charge	
D0180	Comprehensive periodontal evaluation – new or established patient	No charge	*Included with D0150*
D0190	Screening of a patient	Not covered	
D0191	Assessment of a patient	Not covered	
D0210	Intraoral - comprehensive series of radiographic images	No charge	*1 series per 36 months per Contract Dentist*
D0220	Intraoral - periapical first radiographic image	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*
D0230	Intraoral - periapical each additional radiographic image	No charge	*20 images (D0220, D0230) per 12 months per Contract Dentist*
D0240	Intraoral - occlusal radiographic image	No charge	*2 per 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*
D0251	Extra-oral posterior dental radiographic image	No charge	*4 per date of service*
D0270	Bitewing - single radiographic image	No charge	*1 of (D0270, D0273) per date of service*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations for Pediatric Enrollees
D0272	Bitewings - two radiographic images	No charge	*1 of (D0272, D0273) per 6 months per Contract Dentist*
D0273	Bitewings - three radiographic images	No charge	*1 of (D0270, D0273) per date of service; 1 of (D0272, D0273) per 6 months per Contract Dentist*
D0274	Bitewings - four radiographic images	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*
D0277	Vertical bitewings - 7 to 8 radiographic images	No charge	*1 of (D0274, D0277) per 6 months per Contract Dentist*
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 per 12 months per Contract Dentist*
D0330	Panoramic radiographic image	No charge	*1 per 36 months per Contract Dentist*
D0340	2D cephalometric radiographic image - acquisition, measurement and analysis	No charge	*2 per 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*
D0396	3D printing of a 3D dental surface scan	No charge	
D0460	Pulp vitality tests	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 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0602	Caries risk assessment and documentation, with a finding of moderate risk	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0603	Caries risk assessment and documentation, with a finding of high risk	No charge	*1 of (D0601, D0602, D0603) per 12 months per Contract Dentist or dental office*
D0701	Panoramic radiographic image - image capture only	No charge	
D0702	2D cephalometric radiographic image - image capture only	No charge	
D0703	2D oral/facial photographic image obtained intra-orally or extra-orally - image capture only	No charge	
D0705	Extra-oral posterior dental radiographic image - image capture only	No charge	
D0706	Intraoral - occlusal radiographic image - image capture only	No charge	
D0707	Intraoral - periapical radiographic image - image capture only	No charge	
D0708	Intraoral - bitewing radiographic image – image capture only	No charge	
D0709	Intraoral - comprehensive series of radiographic images - image capture only	No charge	
D0801	3D intraoral surface scan - direct	No charge	*1 per date of service*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations for Pediatric Enrollees
D0802	3D dental surface scan - indirect	No charge	*1 per date of service*
D0803	3D facial surface scan - direct	No charge	*1 per date of service*
D0804	3D facial surface scan - indirect	No charge	*1 per date of service*

D1000-D1999 II. PREVENTIVE

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D1110	Prophylaxis - adult	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1120	Prophylaxis - child	No charge	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D1206	Topical application of fluoride varnish	No charge	*2 of (D1206, D1208) per 12 months*
D1208	Topical application of fluoride - excluding varnish	No charge	*2 of (D1206, D1208) per 12 months*
D1310	Nutritional counseling for control of dental disease	No charge	
D1320	Tobacco counseling for the control and prevention of oral disease	No charge	
D1321	Counseling for the control and prevention of adverse oral, behavioral, and systemic health effects associated with high-risk substance use	No charge	
D1330	Oral hygiene instructions	No charge	
D1351	Sealant - per tooth	No charge	*1 per tooth per 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 Contract Dentist or dental office is responsible for any repair or replacement during the 36-month period*
D1354	Application of caries arresting medicament - per tooth	No charge	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*
D1355	Caries preventive medicament application - per tooth	No charge	*1 per tooth per 6 months when Enrollee has a caries risk assessment and documentation, with a finding of "high risk"*
D1510	Space maintainer – fixed, unilateral – per quadrant	No charge	*1 per quadrant; posterior teeth*
D1516	Space maintainer - fixed – bilateral, maxillary	No charge	*1 per arch; posterior teeth*
D1517	Space maintainer - fixed – bilateral, mandibular	No charge	*1 per arch; posterior teeth*
D1520	Space maintainer – removable, unilateral – per quadrant	No charge	*1 per quadrant; posterior teeth*
D1526	Space maintainer - removable – bilateral, maxillary	No charge	*1 per arch, through age 17; posterior teeth*
D1527	Space maintainer - removable – bilateral, mandibular	No charge	*1 per arch, through age 17; posterior teeth*
D1551	Re-cement or re-bond bilateral space maintainer - maxillary	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1552	Re-cement or re-bond bilateral space maintainer - mandibular	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D1553	Re-cement or re-bond unilateral space maintainer - per quadrant	No charge	*1 per Contract Dentist, per quadrant or arch, through age 17*
D1556	Removal of fixed unilateral space maintainer - per quadrant	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1557	Removal of fixed bilateral space maintainer – maxillary	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1558	Removal of fixed bilateral space maintainer - mandibular	No charge	*Included in case by Contract Dentist or dental office who placed appliance*
D1575	Distal shoe space maintainer – fixed, unilateral – per quadrant	No charge	*1 per quadrant, age 8 and under; posterior teeth*

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.

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D2140	Amalgam - one surface, primary or permanent	$25	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2150	Amalgam - two surfaces, primary or permanent	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2160	Amalgam - three surfaces, primary or permanent	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2161	Amalgam - four or more surfaces, primary or permanent	$45	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2330	Resin-based composite - one surface, anterior	$30	*1 per 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 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2332	Resin-based composite - three surfaces, anterior	$55	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2335	Resin-based composite - four or more surfaces (anterior)	$60	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2390	Resin-based composite crown, anterior	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2391	Resin-based composite - one surface, posterior	$30	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2392	Resin-based composite - two surfaces, posterior	$40	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D2393	Resin-based composite - three surfaces, posterior	$50	*1 per 12 months per Contract Dentist for primary teeth; 1 per 36 months per Contract Dentist for permanent teeth*
D2394	Resin-based composite - four or more surfaces, posterior	$70	*1 per 12 months per Contract Dentist for primary teeth; 1 per 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 - ¾ 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	$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 per 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 Delta Dental is permitted. The listed Cost Share applies for service provided by a Contract Dentist other than the original treating Contract Dentist/dental office.*
D2921	Reattachment of tooth fragment, incisal edge or cusp	$45	*1 per 12 months*
D2928	Prefabricated porcelain/ceramic crown - permanent tooth	$120	*1 per 36 months*
D2929	Prefabricated porcelain/ceramic crown – primary tooth	$95	*1 per 12 months*
D2930	Prefabricated stainless steel crown – primary tooth	$65	*1 per 12 months*
D2931	Prefabricated stainless steel crown - permanent tooth	$75	*1 per 36 months*
D2932	Prefabricated resin crown	$75	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*
D2933	Prefabricated stainless steel crown with resin window	$80	*1 per 12 months for primary teeth; 1 per 36 months for permanent teeth*
D2940	Placement of interim direct restoration	$25	*1 per 6 months per Contract Dentist*
D2949	Restorative foundation for an indirect restoration	$45	
D2950	Core buildup, including any pins when required	$20	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D2951	Pin retention - per tooth, in addition to restoration	$25	*1 per tooth regardless of the number of pins placed; permanent teeth*
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 customize a crown to fit under an 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*
D2976	Band stabilization – per tooth	$40	*1 per tooth per lifetime*
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.*
D2989	Excavation of a tooth resulting in the determination of non-restorability	$50	
D2991	Application of hydroxyapatite regeneration medicament – per tooth	No charge	*2 per tooth per 12 months*
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

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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, premolar tooth (excluding final restoration)	$235	*Root canal*
D3330	Endodontic therapy, molar tooth (excluding final restoration)	$300	*Root canal*
D3331	Treatment of root canal obstruction; non-surgical access	$50	
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 Delta Dental. 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 - premolar	$295	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or Delta Dental. 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	$350	*Retreatment during the 12 months following initial treatment is included at no charge to the Enrollee or Delta Dental. 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 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3421	Apicoectomy - premolar (first root)	$250	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3425	Apicoectomy - molar (first root)	$275	*1 per 24 months by the same Contract Dentist or dental office; permanent teeth only*
D3426	Apicoectomy (each additional root)	$110	*1 per 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*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D3428	Bone graft in conjunction with periradicular surgery - per tooth, single site	$350	
D3429	Bone graft in conjunction with periradicular surgery - each additional contiguous tooth in the same surgical site	$350	
D3430	Retrograde filling - per root	$90	
D3431	Biologic materials to aid in soft and osseous tissue regeneration in conjunction with periradicular surgery	$80	
D3471	Surgical repair of root resorption - anterior	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3472	Surgical repair of root resorption - premolar	$160	*1 per 24 months by the same Contract Dentist or dental office*
D3473	Surgical repair of root resorption - molar	$160	*1 per 24 months by the same Contract Dentist or dental office*
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 pre-operative and post-operative evaluations and treatment under a local anesthetic

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	$150	*1 per quadrant per 36 months, age 13+*
D4211	Gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	$50	*1 per quadrant per 36 months, age 13+*
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 per 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 per 36 months, age 13+*
D4265	Biologic materials to aid in soft and osseous tissue regeneration, per site	$80	
D4341	Periodontal scaling and root planing - four or more teeth per quadrant	$55	*1 per quadrant per 24 months, age 13+*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D4342	Periodontal scaling and root planing - one to three teeth per quadrant	$30	*1 per quadrant per 24 months, age 13+*
D4346	Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	$40	*Cleaning; 1 of (D1110, D1120, D4346) per 6 months*
D4355	Full mouth debridement to enable a comprehensive periodontal evaluation and diagnosis on a subsequent visit	$40	*1 treatment per 12 consecutive months*
D4381	Localized delivery of antimicrobial agents via a 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, Cost Share 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.

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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 retentive/clasping materials, rests and teeth)	$300	*1 per 60 months*
D5212	Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$300	*1 per 60 months*
D5213	Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$335	*1 per 60 months*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D5214	Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$335	*1 per 60 months*
D5221	Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	$275	*1 per 60 months*
D5222	Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	$275	*1 per 60 months*
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330	*1 per 60 months*
D5224	Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	$330	*1 per 60 months*
D5410	Adjust complete denture - maxillary	$20	*1 per day of service per Contract Dentist; up to 2 per 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 per 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 per 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 per 12 months per Contract Dentist after the initial 6 months*
D5511	Repair broken complete denture base, mandibular	$40	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5512	Repair broken complete denture base, maxillary	$40	*1 per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5520	Replace missing or broken teeth - complete denture - per tooth	$40	*Up to 4 per arch per date of service after the initial 6 months; up to 2 per arch per 12 months per Contract Dentist*
D5611	Repair resin partial denture base, mandibular	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5612	Repair resin partial denture base, maxillary	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5621	Repair cast partial framework, mandibular	$40	*1 per arch, per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5622	Repair cast partial framework, maxillary	$40	*1 per arch per day of service per Contract Dentist; up to 2 per arch per 12 months per Contract Dentist after the initial 6 months*
D5630	Repair or replace broken retentive/clasping materials - per tooth	$50	*3 per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D5640	Replace missing or broken teeth - partial denture - per tooth	$35	*4 per arch per date of service after the initial 6 months; 2 per arch per 12 months per Contract Dentist*
D5650	Add tooth to existing partial denture - per tooth	$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 per 12 months per Contract Dentist*
D5730	Reline complete maxillary denture (direct)	$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 (direct)	$60	*1 per 12-month period after the initial 6 months*
D5740	Reline maxillary partial denture (direct)	$60	*1 per 12-month period after the initial 6 months*
D5741	Reline mandibular partial denture (direct)	$60	*1 per 12-month period after the initial 6 months*
D5750	Reline complete maxillary denture (indirect)	$90	*1 per 12-month period after the initial 6 months*
D5751	Reline complete mandibular denture (indirect)	$90	*1 per 12-month period after the initial 6 months*
D5760	Reline maxillary partial denture (indirect)	$80	*1 per 12-month period after the initial 6 months*
D5761	Reline mandibular partial denture (indirect)	$80	*1 per 12-month period after the initial 6 months*
D5850	Tissue conditioning, maxillary	$30	*2 per prosthesis per 36 months after the initial 6 months*
D5851	Tissue conditioning, mandibular	$30	*2 per prosthesis per 36 months after the initial 6 months*
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 - natural tooth borne	$300	*1 per 60 months*
D5864	Overdenture - partial maxillary - natural tooth borne	$300	*1 per 60 months*
D5865	Overdenture - complete mandibular - natural tooth borne	$300	*1 per 60 months*
D5866	Overdenture - partial mandibular - natural tooth borne	$300	*1 per 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*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
			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.

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D5909	Maxillary guidance prosthesis with guide flange	$350	
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	
D5930	Maxillary guidance prosthesis without guide flange	$350	
D5931	Obturator prosthesis, surgical	$350	
D5932	Obturator prosthesis, definitive	$350	
D5933	Obturator prosthesis, modification	$150	*2 per 12 months*
D5934	Mandibular guidance prosthesis with guide flange	$350	
D5935	Mandibular guidance prosthesis without guide flange	$350	
D5936	Obturator prosthesis, interim	$350	
D5937	Trismus appliance (not for TMD treatment)	$85	
D5938	Resection prosthesis, maxillary complete removable	$350	
D5939	Resection prosthesis, mandibular complete removable	$350	
D5940	Resection prosthesis, maxillary partial removable	$350	
D5941	Resection prosthesis, mandibular partial removable	$350	
D5942	Resection prosthesis, maxillary implant/abutment supported removable prosthesis for edentulous arch	$350	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D5943	Resection prosthesis, mandibular implant/abutment supported removable prosthesis for edentulous arch	$350	
D5944	Resection prosthesis, maxillary implant/abutment supported removable prosthesis for the partial edentulous arch	$350	
D5945	Resection prosthesis, mandibular implant/abutment supported removable prosthesis for the partial edentulous arch	$350	
D5946	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for edentulous arch	$350	
D5947	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for edentulous arch	$350	
D5948	Resection prosthesis, maxillary implant/abutment supported fixed prosthesis for the partial edentulous arch	$350	
D5949	Resection prosthesis, mandibular implant/abutment supported fixed prosthesis for the partial edentulous arch	$350	
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	
D5958	Palatal lift prosthesis, interim	$350	
D5959	Palatal lift prosthesis, modification	$145	*2 per 12 months*
D5960	Speech aid prosthesis, modification	$145	*2 per 12 months*
D5982	Surgical stent for soft tissue healing	$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.

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D6010	Surgical placement of implant body: endosteal implant	$350	*A Benefit only under exceptional medical conditions.*
D6011	Surgical access to an implant body (second stage implant surgery)	$350	*A Benefit only under exceptional medical conditions.*
D6012	Surgical placement of interim implant body for transitional prosthesis: endosteal implant	$350	*A Benefit only under exceptional medical conditions.*
D6013	Surgical placement of mini implant	$350	*A Benefit only under exceptional medical conditions.*
D6040	Surgical placement: eposteal implant	$350	*A Benefit only under exceptional medical conditions.*
D6049	Scaling and debridement of a single implant in the presence of peri-implantitis inflammation, bleeding upon probing and increased pocket depths, including cleaning of the implant surfaces, without flap entry and closure	$35	
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 crown - porcelain fused to high noble alloys	$335	*A Benefit only under exceptional medical conditions.*
D6067	Implant supported crown high noble alloys	$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.*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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 FPD - porcelain fused to high noble alloys	$330	*A Benefit only under exceptional medical conditions.*
D6077	Implant supported retainer for metal FPD high noble alloys	$350	*A Benefit only under exceptional medical conditions.*
D6080	Implant maintenance procedures when a full arch prosthesis is removed and reinserted, including cleansing of prosthesis and abutments	$30	*A Benefit only under exceptional medical conditions.*
D6081	Scaling and debridement of a single implant in the presence of mucositis, including inflammation, bleeding upon probing and increased pocket depths; includes cleaning of the implant surfaces, without flap entry and closure	$30	*A Benefit only under exceptional medical conditions.*
D6082	Implant supported crown - porcelain fused to predominantly base alloys	$335	*A Benefit only under exceptional medical conditions*
D6083	Implant supported crown - porcelain fused to noble alloys	$335	*A Benefit only under exceptional medical conditions*
D6084	Implant supported crown - porcelain fused to titanium and titanium alloys	$335	*A Benefit only under exceptional medical conditions*
D6085	Interim implant crown	$300	*A Benefit only under exceptional medical conditions.*
D6086	Implant supported crown - predominantly base alloys	$340	*A Benefit only under exceptional medical conditions*
D6087	Implant supported crown - noble alloys	$340	*A Benefit only under exceptional medical conditions*
D6088	Implant supported crown - titanium and titanium alloys	$340	*A Benefit only under exceptional medical conditions*
D6089	Accessing and retorquing loose implant screw – per screw	$60	*1 per 24 months*
D6090	Repair of implant/abutment supported prosthesis	$65	*A Benefit only under exceptional medical conditions.*
D6091	Replacement of replaceable part of semi-precision or precision attachment 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 and titanium alloys	$295	*A Benefit only under exceptional medical conditions.*
D6096	Remove broken implant retaining screw	$60	*A Benefit only under exceptional medical conditions*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D6097	Abutment supported crown - porcelain fused to titanium and titanium alloys	$315	*A Benefit only under exceptional medical conditions*
D6098	Implant supported retainer - porcelain fused to predominantly base alloys	$330	*A Benefit only under exceptional medical conditions*
D6099	Implant supported retainer for FPD - porcelain fused to noble alloys	$330	*A Benefit only under exceptional medical conditions*
D6100	Surgical removal of implant body	$110	*A Benefit only under exceptional medical conditions.*
D6105	Removal of implant body not requiring bone removal or flap elevation	$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 edentulous arch – maxillary	$350	*A Benefit only under exceptional medical 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.*
D6118	Implant/abutment supported interim fixed denture for edentulous arch - mandibular	$350	*A Benefit only under exceptional medical conditions.*
D6119	Implant/abutment supported interim fixed denture for edentulous arch - maxillary	$350	*A Benefit only under exceptional medical conditions.*
D6120	Implant supported retainer - porcelain fused to titanium and titanium alloys	$330	*A Benefit only under exceptional medical conditions*
D6121	Implant supported retainer for metal FPD - predominantly base alloys	$350	*A Benefit only under exceptional medical conditions*
D6122	Implant supported retainer for metal FPD - noble alloys	$350	*A Benefit only under exceptional medical conditions*
D6123	Implant supported retainer for metal FPD - titanium and titanium alloys	$350	*A Benefit only under exceptional medical conditions*
D6180	Implant maintenance procedures when a full arch fixed hybrid prosthesis is not removed, including cleansing of prosthesis and abutments	$30	*A Benefit only under exceptional medical conditions*
D6190	Radiographic/surgical implant index, by report	$75	*A Benefit only under exceptional medical conditions.*
D6191	Semi-precision abutment - placement	$350	*A Benefit only under exceptional medical conditions.*
D6192	Semi-precision attachment - placement	$350	*A Benefit only under exceptional medical conditions.*
D6194	Abutment supported retainer crown for FPD - titanium and titanium alloys	$265	*A Benefit only under exceptional medical conditions.*
D6195	Abutment supported retainer - porcelain fused to titanium and titanium alloys	$315	*A Benefit only under exceptional medical conditions*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D6197	Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant	$95	*A Benefit only under exceptional medical conditions.*
D6198	Remove interim implant component	$110	*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.

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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+*
D6280	Implant maintenance procedures when a full arch removable implant/abutment supported denture is removed and reinserted, including cleansing of prosthesis and abutments - per arch	$20	
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+*
D6784	Retainer crown - 3/4 titanium and titanium alloys	$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 Delta Dental 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*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
			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 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 pre-operative and post-operative evaluations and treatment under a local anesthetic. Post-operative services include exams, suture removal and treatment of complications.

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D7111	Extraction, coronal remnants – primary tooth	$40	
D7140	Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	$65	
D7210	Extraction, 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	Removal of residual tooth roots (cutting procedure)	$80	
D7252	Partial extraction for immediate implant placement	$80	*1 per lifetime per tooth, in conjunction with immediate implant placement*
D7259	Nerve dissection	$280	
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	Exposure of an unerupted tooth	$220	
D7283	Placement of device to facilitate eruption of impacted tooth	$85	*For active orthodontic treatment only*
D7284	Excisional biopsy of minor salivary glands	$115	*1 in same day*
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*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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 hyperplastic tissue)	$350	*1 per arch*
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	Reduction of osseous tuberosity	$105	*1 per quadrant*
D7490	Radical resection of maxilla or mandible	$350	
D7509	Marsupialization of odontogenic cyst	$180	
D7510	Incision and drainage of abscess – intraoral soft tissue	$70	*1 per quadrant per date of service*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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 immobilized, if present)	$350	
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 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	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
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: lavage and lysis of adhesions	$350	
D7874	Arthroscopy: disc repositioning and stabilization	$350	
D7875	Arthroscopy: synovectomy	$350	
D7876	Arthroscopy: discectomy	$350	
D7877	Arthroscopy: debridement	$350	
D7880	Occlusal orthotic device, by report	$120	
D7881	Occlusal orthotic device adjustment	$30	*1 per date of service per Contract Dentist; 2 per 12 months per Contract Dentist*
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	
D7920	Skin graft (identify defect covered, location and type of graft)	$120	
D7922	Placement of intra-socket biological dressing to aid in hemostasis or clot stabilization, per site	$80	
D7939	Indexing for osteotomy using dynamic robotic assisted or dynamic navigation	$350	1 per tooth per 60 months
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	

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D7961	Buccal/labial frenectomy (frenulectomy)	$120	*1 per arch per date of service; a Benefit only when the permanent incisors and cuspids have erupted*
D7962	Lingual frenectomy (frenulectomy)	$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*
D7979	Non - surgical sialolithotomy	$155	
D7980	Surgical 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 pertinent history and the actual treatment.*

D8000-D8999 XI. ORTHODONTICS - Medically Necessary for Pediatric Enrollees ONLY

- 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 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 orthodontist or dental office.

- Limited orthodontic treatment (any dentition) and comprehensive orthodontic treatment (any dentition) are part of comprehensive orthodontic treatment with orthognathic surgery.

- 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.

- Refer to Schedule B for additional information on Medically Necessary orthodontics.

*- *Pediatric Enrollee pays a one-time Cost Share of $1,000 for the orthodontic Benefit, which includes Medically Necessary covered codes between D8080-D8999.*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D8080	Comprehensive orthodontic treatment of the adolescent dentition	$1,000*	*1 per Enrollee per phase of treatment; included in comprehensive case fee*
D8091	Comprehensive orthodontic treatment with orthognathic surgery	$1,000*	*1 per Enrollee per phase of treatment; included in comprehensive case fee*
D8210	Removable appliance therapy	$1,000*	*1 per lifetime; age 6 through 12; included in comprehensive case fee*
D8220	Fixed appliance therapy	$1,000*	*1 per lifetime; age 6 through 12; included in comprehensive case fee*
D8660	Pre-orthodontic treatment examination to monitor growth and development	$1,000*	*1 per 3 months when performed by the same Contract Dentist or dental office; up to 6 visits per lifetime; included in comprehensive case fee*
D8670	Periodic orthodontic treatment visit	$1,000*	*Included in comprehensive case fee*
D8671	Periodic orthodontic treatment visit associated with orthognathic surgery	$1,000*	*Included in comprehensive case fee*
D8680	Orthodontic retention (removal of appliances, construction and placement of retainer(s))	$1,000*	*1 per arch for each authorized phase of orthodontic treatment; included in comprehensive case fee*
D8681	Removable orthodontic retainer adjustment	$1,000*	*Included in comprehensive case fee*
D8696	Repair of orthodontic appliance – maxillary	$1,000*	*1 per appliance; included in comprehensive case fee*
D8697	Repair of orthodontic appliance – mandibular	$1,000*	*1 per appliance; included in comprehensive case fee*
D8698	Re-cement or re-bond fixed retainer – maxillary	$1,000*	*1 per Contract Dentist; included in comprehensive case fee*
D8699	Re-cement or re-bond fixed retainer – mandibular	$1,000*	*1 per Contract Dentist; included in comprehensive case fee*
D8701	Repair of fixed retainer, includes reattachment – maxillary	$1,000*	*1 per Contract Dentist; included in comprehensive case fee. The Cost Share applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*
D8702	Repair of fixed retainer, includes reattachment – mandibular	$1,000*	*1 per Contract Dentist; included in comprehensive case fee. The listed fee applies for services provided by an orthodontist other than the original treating orthodontist or dental office.*
D8703	Replacement of lost or broken retainer - maxillary	$1,000*	*1 per arch; within 24 months following the date of service for orthodontic retention (D8680); included in comprehensive case fee*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D8704	Replacement of lost or broken retainer – mandibular	$1,000*	*1 per arch; within 24 months following the date of service for orthodontic retention (D8680); included in comprehensive case fee*
D8999	Unspecified orthodontic procedure, by report	$1,000*	*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. Included in comprehensive case fee*

D9000-D9999 XII. ADJUNCTIVE GENERAL SERVICES

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D9110	Palliative treatment of dental pain – per visit	$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.*
D9211	Regional block anesthesia	$20	
D9212	Trigeminal division block anesthesia	$60	
D9215	Local anesthesia in conjunction with operative or surgical procedures	$15	
D9219	Evaluation for moderate sedation, deep sedation or general anesthesia	$45	
D9222	Administration of deep sedation/general anesthesia - first 15 minute increment, or any portion thereof	$45	
D9223	Administration of deep sedation/general anesthesia - each subsequent 15 minute increment, or any portion thereof	$45	
D9224	Administration of general anesthesia with advanced airway - first 15 minute increment, or any portion thereof	$65	
D9225	Administration of general anesthesia with advanced airway - each subsequent 15 minute increment, or any portion thereof	$65	
D9230	Administration of nitrous oxide	$15	*(Where available)*
D9239	Administration of moderate sedation - intravenous - first 15 minute increment, or any portion thereof	$60	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*
D9243	Administration of moderate sedation - intravenous - each subsequent 15 minute increment, or any portion thereof	$60	*Covered only when given by a Contract Dentist for covered oral surgery; 4 of (D9239, D9243) per date of service*

Code	Description	Pediatric Enrollee Pays	Clarifications/Limitations
D9244	In-office administration of minimal sedation - single drug - enteral	$30	
D9245	Administration of moderate sedation - enteral	$65	
D9246	Administration of moderate sedation - non-intravenous parenteral - first 15 minute increment, or any portion thereof	$65	
D9247	Administration of moderate sedation - non-intravenous parenteral - each subsequent 15 minute increment, or any portion thereof	$65	
D9310	Consultation - diagnostic service provided by Dentist or physician other than requesting Dentist or physician	$50	
D9311	Consultation with a medical health care professional	No charge	
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 per 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 per 12 months for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9951	Occlusal adjustment - limited	$45	*1 per 12 months for quadrant per Contract Dentist; age 13+*
D9952	Occlusal adjustment - complete	$210	*1 per 12 months following occlusion analysis - mounted case (D9950) for diagnosed TMJ dysfunction; permanent teeth; age 13+*
D9995	Teledentistry - synchronous; real-time encounter	No charge	
D9996	Teledentistry - asynchronous; information stored and forwarded to dentist for subsequent review	No charge	
D9997	Dental case management - patients with Special Health Care Needs	No charge	
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:

If services for a listed procedure are performed by the assigned Contract Dentist, the Enrollee pays the specified Cost Share. Listed procedures which require a Dentist to provide Specialist Services, and are referred by the assigned Contract Dentist, must be authorized by Delta Dental. The Enrollee pays the Cost Share specified for such services.

Optional or upgraded procedure(s) are defined as any alternative procedure(s) presented by the Contract 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 this Amendment. The applicable charge to the Enrollee is the difference between the Contract Dentist's regularly charged fee (or contracted fee, when applicable) for the Optional or upgraded procedure and the covered procedure, plus any applicable Cost Share for the covered procedure.

Example of an Optional or upgraded procedure:

- If the Enrollee chooses an Optional or upgraded procedure presented by the Contract Dentist,
  - Where noble (D6061, D6064, D6071, D6074, D6083, D6087, D6099, D6122); high noble (precious) (D6059, D6062, D6066, D6067, D6069, D6072, D6076, D6077); or titanium (D6084, D6088, D6094, D6097, D6194, D6195, D6784) metals are used for an implant/abutment supported crown or fixed bridge retainer; and
  - An additional laboratory fee is charged by the Contract Dentist.

Then the Enrollee will be responsible for the fee charged by the laboratory which equals the difference between the higher cost of the Optional service and the lower cost of the customary service or standard procedure.

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.

To the extent the dental plans can offer Teledentistry, it would be offered at no charge.

These Endnotes do not limit an issuer's obligations to comply with applicable Federal, State, or local laws, rules, or regulations. In the event an issuer is subject to a newly enacted or amended law, rule, or regulation that conflicts with the requirements of these Endnotes, an issuer shall comply with the law, rule, or regulation and any applicable guidance from its regulatory authority. Where these Endnotes exceed requirements imposed by law, an issuer shall comply with the requirements in these Endnotes.

SCHEDULE B - Limitations and Exclusions of Benefits

Limitations of Benefits for Pediatric Enrollees

- The frequency of certain Benefits is limited. All frequency limitations are listed in *Schedule A, Description of Benefits and Cost Share for Pediatric Enrollees.* Additional requests, beyond the stated frequency limitations, for prophylaxis, fluoride and scaling procedures [D1110, D1120, D1206, D1208, and D4346] 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.
- A filling [D2140-D2161, D2330-D2335, D2391-D2394] is a Benefit for the removal of decay, for minor repairs of tooth structure or to replace a lost filling.
- A crown [D2390 and covered codes only between D2710-D2791] 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.
- The replacement of an existing crown [D2390 and covered codes only between D2710-D2791], fixed partial denture (bridge) [covered codes only between D6211-D6245, D6251, D6721-D6791] or a removable full [D5110, D5120] or partial denture [covered codes only between D5211-D5214, D5221-D5224] is covered when:
  - ♦ The existing restoration/bridge/denture is no longer functional and cannot be made functional by repair or adjustment, **and**
  - ♦ 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.
- Coverage for the placement of a fixed partial denture (bridge) [covered codes only between D6211-D6245, D6251, D6721-D6791] or removable partial denture [covered codes only between D5211-D5214, D5221-D5224]:
  - ♦ 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 the limitation in the third bullet point.
  - ♦ Removable partial denture:
    - Cast metal [D5213, D5214, D5223, D5224], one or more teeth are missing in an arch.
    - Resin based [D5211, D5212, D5221, D5222], one or more teeth are missing in an arch and abutment teeth have extensive periodontal disease.
- Immediate dentures [D5130, D5140, D5221-D5224] are covered when one or more of the following conditions are present:
  - ♦ extensive or rampant caries are exhibited in the radiographs, **or**
  - ♦ severe periodontal involvement indicated, **or**
  - ♦ numerous teeth are missing resulting in diminished chewing ability adversely affecting the Enrollee's health.
- Maxillofacial prosthetic services [covered codes only between D5911-D5999] are 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.

- All maxillofacial prosthetic procedures [covered codes only between D5911-D5999] require prior Authorization for Medically Necessary procedures.
- Implant services [covered codes only between D6010-D6199] are a Benefit only under exceptional medical conditions. Exceptional medical conditions include, but are not limited to:
  - ♦ 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.
  - ♦ severe atrophy of the mandible and/or maxilla that cannot be corrected with vestibular extension procedures [D7340, D7350] or osseous augmentation procedures [D7950], and the Enrollee is unable to function with conventional prosthesis.
  - ♦ skeletal deformities that preclude the use of conventional prosthesis (such as arthrogryposis, ectodermal dysplasia, partial anodontia and cleidocranial dysplasia).
- Temporomandibular joint ("TMJ") dysfunction procedure codes [covered codes only between D7810-D7880] are limited to differential diagnosis and symptomatic care and require prior Authorization.
- Certain listed procedures performed by a Contract Specialist may be considered primary under the Enrollee's medical coverage. Dental Benefits will be coordinated accordingly.
- Administration of deep sedation/general anesthesia [D9222-D9225] or administration of moderate sedation – intravenous [D9239-D9243] for covered procedures requires documentation to justify the medical necessity based on a mental or physical limitation or contraindication to a local anesthesia agent.
- When performed in conjunction with the removal of an impacted tooth, complete bony with unusual surgical complications, nerve dissection is included with the extraction procedure. Otherwise, nerve dissection is not a Benefit [D7259].

Exclusions of Benefits for Pediatric Enrollees

- Any procedure that is not specifically listed under *Schedule A*, *Description of Benefits and Cost Share for Pediatric Enrollees*, except as required by state or federal law.
- All related fees for admission, use, or stays in a hospital, out-patient surgery center, extended care facility, or other similar care facility.
- Lost or theft of full or partial dentures [covered codes only between D5110, D5140, D5211, D5214, D5221, D5224], space maintainers [D1510-D1575], crowns [D2390 and covered codes only between D2710-D2791], fixed partial dentures (bridges) [covered codes only between D6211-D6245, D6251, D6721-D6791] or other appliances.
- Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage.
- Dental expenses incurred in connection with any dental procedure before the Enrollee's eligibility in this Amendment. Examples include: teeth prepared for crowns, partials and dentures, root canals in progress.
- Dispensing of drugs not normally supplied in a dental facility unless included in *Schedule A*.
- Any procedure that in the professional opinion of the Contract Dentist, Contract Specialist, or dental plan consultant:
  - ♦ has poor prognosis for a successful result and reasonable longevity based on the condition of the tooth or teeth and/or surrounding structures, **or**
  - ♦ is inconsistent with generally accepted standards for dentistry.
- 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 the "Emergency Dental Services" and "Urgent Dental Services" sections of the Amendment. To obtain written Authorization, the Enrollee should call Delta Dental's Customer Care at **800-589-4618**.
- Consultations [D9310, D9311] or other diagnostic services [covered codes only between D0120-D0999] for non-covered Benefits.
- Single tooth implants [covered codes only between D6000-D6199].

- Restorations [covered codes only between D2330-D2335, D2391-D2394, D2710-D2791, D6211-D6245, D6251, D6721-D6791] placed solely due to cosmetics, abrasions, attrition, erosion, restoring or altering vertical dimension.
- Preventive [covered codes only between D1110-D1575], endodontic [covered codes only between D3110-D3999] or restorative procedures [covered codes only between D2140-D2999] are not a Benefit for teeth to be retained for overdentures.
- Partial dentures [covered codes only between D5211-5214, D5221-D5224] 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.
- Appliances or restorations necessary to increase vertical dimension, replace or stabilize tooth structure loss by attrition, realignment of teeth [covered codes only between D8000-D8999], periodontal splinting [D4322-D4323], gnathologic recordings, equilibration [D9952] or treatment of disturbances of the TMJ [covered codes only between D0310-D0322, D7810-D7899], unless included in *Schedule A*.
- Porcelain denture teeth or fixed partial dentures (overlays, implants, and appliances associated therewith) [D6940, D6950] and personalization and characterization of complete and partial dentures.
- Extraction of teeth [D7111, D7140, D7210, D7220-D7240, D7241, D7250], when teeth are asymptomatic/non-pathologic (no signs or symptoms of pathology or infection), including but not limited to the removal of third molars.
- TMJ dysfunction treatment modalities that involve prosthodontia [D5110-D5224, D6211-D6245, D6251, D6721-D6791], orthodontia [covered codes only between D8000-D8999], and full or partial occlusal rehabilitation or TMJ dysfunction procedures [covered codes only between D0310-D0322, D7810-D7899] solely for the treatment of bruxism.
- Vestibuloplasty/ridge extension procedures [D7340, D7350] performed on the same date of service as extractions [D7111-D7250] on the same arch.
- Administration of deep sedation/general anesthesia [D9222-D9225] for covered procedures on the same date of service as administration of nitrous oxide or for administration of moderate sedation – intravenous [D9230, D9239, D9243].
- Administration of moderate sedation – intravenous [D9239, D9243] for covered procedures on the same date of service as administration of nitrous oxide or for administration of deep sedation/general anesthesia [D9222-D9225].
- Administration of nitrous oxide [D9230] when administered with other covered sedation procedures.
- Cosmetic dental care [exclude covered codes in this list if done for purely cosmetic reasons: D2330-D2394, D2710-D2751, D2940, D6211-D6245, D6251, D6721-D6791, D8000-D8999].
- Services or supplies for sleep apnea.
- Administration of neuromodulators is not a Benefit of the plan.
- Administration of dermal fillers is not a Benefit of the plan.

Medically Necessary Orthodontics for Pediatric Enrollees

- Orthodontic Services are limited to the following automatic qualifying conditions:
  - Cleft palate deformity. If the cleft palate is not visible on the diagnostic casts written documentation from a Contract Orthodontist or Contract Specialist shall be submitted on their professional letterhead with the prior Authorization request.
  - Craniofacial anomaly. Written documentation from a Contract Orthodontist or Contract Specialist shall be submitted on their professional letterhead with the prior Authorization request.
  - A deep impinging overbite in which the lower incisors are destroying the soft tissue of the palate.
  - A crossbite of individual anterior teeth causing destruction of soft tissue.
  - An overjet greater than 9 mm or reverse overjet greater than 3.5 mm.
  - Severe traumatic deviation.
- The following documentation must be submitted with the request for prior Authorization of services by the Contract Orthodontist:
  - ADA 2006 or newer claim form with service code(s) requested;

- Diagnostic study models (trimmed) with bite registration; or OrthoCad equivalent;
- Cephalometric radiographic image or panoramic radiographic image;
- HLD score sheet completed and signed by the Contract Orthodontist; and
- Treatment plan.

- Coverage for comprehensive orthodontic treatment [D8080] 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 [D0470]. Comprehensive orthodontic treatment [D8080]:
  - 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
  - may start at birth for patients with a cleft palate or craniofacial anomaly.
- 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.
- The Benefit for a pre-orthodontic treatment examination [D8660] includes needed oral/facial photographic images [D0350, D0703, D0801, D0802, D0803, D0804]. Neither the Enrollee nor Delta Dental may be charged for D0350, D0351, D0703, D0801, D0802, D0803, D0804 in conjunction with a pre-orthodontic treatment examination.
- The number of covered periodic orthodontic treatment [D8670] visits and length of covered active orthodontics is limited to a maximum of up to:
  - handicapping malocclusion - eight (8) quarterly visits;
  - cleft palate or craniofacial anomaly - six (6) quarterly visits for treatment of primary dentition;
  - cleft palate or craniofacial anomaly - eight (8) quarterly visits for treatment of mixed dentition; or
  - cleft palate or craniofacial anomaly - ten (10) quarterly visits for treatment of permanent dentition.
  - facial growth management - four (4) quarterly visits for treatment of primary dentition;
  - facial growth management - five (5) quarterly visits for treatment of mixed dentition;
  - facial growth management - eight (8) quarterly visits for treatment permanent dentition.
- Orthodontic retention [D8680] is a separate Benefit after the completion of covered comprehensive orthodontic treatment [D8080] which:
  - includes removal of appliances and the construction and place of retainer(s) [D8680]; and
  - is limited to Enrollees under age 19 and 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.
- All Orthodontic services, including direct to consumer orthodontics, must be provided by a licensed Dentist authorized to deliver care in the Enrollee's state. Claims for services that are not provided by a Dentist are not eligible for reimbursement.
- Cost Share is payable to the Contract Orthodontist who initiates banding in a course of prior authorized orthodontic treatment [covered codes only between D8000-D8999]. If, after banding has been initiated, the Enrollee changes to another Contract Orthodontist to continue orthodontic treatment, the Enrollee:
  - will not be entitled to a refund of any amounts previously paid, and
  - will be responsible for all payments, up to and including the full Cost Share, that are required by the new Contract Orthodontist for completion of the orthodontic treatment.
- 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 [covered codes only between D8000-D8999], 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:
  - 60 days if the Enrollee is making monthly payments to the Contract Orthodontist; or
  - 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 submitted 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.

- Orthodontics, including oral evaluations and all treatment, [covered codes only between D8000-D8999] must be performed by a licensed Dentist or their supervised staff, acting within the scope of applicable law.
- The removal of fixed orthodontic appliances [D8680] for reasons other than completion of treatment is not a covered Benefit.

SCHEDULE C - Information Concerning Benefits Under The DeltaCare USA Program

THIS MATRIX IS INTENDED TO BE USED TO COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THIS AMENDMENT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF PROGRAM BENEFITS AND LIMITATIONS.

Deductibles

None

Lifetime Maximums

None

Out-of-Pocket Maximum

Covered pediatric dental services apply to the Plan Out-of-Pocket Maximum in your Health Plan *EOC*. See your Health Plan *EOC* for information about your Plan Out-of-Pocket Maximum.

Professional Services

An Enrollee may be required to pay a Cost Share amount for each procedure as shown in *Schedule A, Description of Benefits and Cost Share for Pediatric Enrollees*, subject to the limitations and exclusions of the Program. Cost Share ranges by category of service.

Examples are as follows:

Diagnostic Services	No charge
Preventive Services	No charge
Restorative Services	$20.00 - $310.00
Endodontic Services	$20.00 - $350.00
Periodontic Services	$10.00 - $350.00
Prosthodontic Services (removable)	$20.00 - $350.00
Maxillofacial Prosthetics	$35.00 - $350.00
Implant Services (Medically Necessary only)	$25.00 - $350.00
Prosthodontic Services (fixed)	$20.00 - $350.00
Oral and Maxillofacial Surgery	$30.00 - $350.00
Orthodontic Services (Medically Necessary only)	$1,000.00 - $1,000.00
Adjunctive General Services	No charge - $210.00

NOTE: Limitations apply to the frequency with which some services may be obtained. For example: cleanings are limited to one in a 6-month period.

Outpatient Services

Not Covered

Hospitalization Services

Not Covered

Emergency Dental Coverage

Benefits for Emergency Dental Services by an Out-of-Network Dentist are limited to necessary care to stabilize the Enrollee's condition and/or provide palliative relief.

Ambulance Services

Not Covered

Prescription Drug Services

Not Covered

Durable Medical Equipment

Not Covered

Mental Health Services
Not Covered
Chemical Dependency Services
Not Covered
Home Health Services
Not Covered
Other
Not Covered

Each individual procedure within each category listed above, and that is covered under the Program, has a specific Cost Share that is shown in *Schedule A, Description of Benefits and Cost Share for Pediatric Enrollees* in this Amendment.

If you have any questions or need additional information, call or write:

Toll Free
800-589-4618

Delta Dental Insurance Company
P.O. Box 1803
Alpharetta, GA 30023-1803

Important Notices

Notice of Language Assistance

English: ATTENTION. Timely language assistance is available at no cost to you. You can ask for interpreter services, including sign language interpreters. You can ask for materials translated into your language or alternative formats, such as braille, audio, or large print. You can also request auxiliary aids and devices at our facilities. Call our Member Services department for help. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week

Arabic: انتباه المساعدة اللغوية متوفرة في الوقت المناسب بدون تكلفة عليك. يمكنك طلب خدمات الترجمة، بما في ذلك مترجمي لغة الإشارة. يمكنك طلب وثائق مترجمة بلغتك أو بصيغ بديلة مثل طريقة برايل للمكفوفين أو ملف صوتي أو الطباعة بأحرف كبيرة. يمكنك أيضًا طلب وسائل مساعدة وأجهزة مساعدة في مرافقنا. اتصل مع قسم خدمات الأعضا (Member Services) لدينا للحصول على المساعدة. قسم خدمات الأعضاء مغلق أيام العطلات الرئيسية.

- Medicare، بما في ذلك D-SNP على: **1-800-443-0815** (TTY **711**)، 8 صباحاً إلى 8 مساءً، 7 أيام في الأسبوع
- Medi-Cal: على **1-855-839-7613** (TTY **711**)، 24 ساعة في اليوم، 7 أيام في الأسبوع
- الآخرين جميعاً: **1-800-464-4000** (TTY **711**)، 24 ساعة في اليوم، 7 أيام في الأسبوع

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Ժամանակին տրամադրվող լեզվական աջակցությունը հասանելի է ձեզ անվճար: Դուք կարող եք խնդրել բանավոր թարգմանության ծառայություններ, այդ թվում՝ ժեստերի լեզվի թարգմանիչներ: Դուք կարող եք խնդրել ձեր լեզվով թարգմանված նյութեր կամ այլընտրանքային ձևաչափեր, ինչպիսիք են՝ բրայլը, ձայնագրությունը կամ խոշոր տառատեսակը: Դուք կարող եք նաև դիմել օժանդակ աջակցության և սարքերի համար, որոնք առկա են մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման բաժին: Անդամների սպասարկման բաժինը (Member Services) փակ է հիմնական տոն օրերին:

- Medicare, ներառյալ D-SNP՝ **1-800-443-0815** (TTY **711**), 8 a.m.-ից 8 p.m.-ը, շաբաթը 7 օր
- Medi-Cal՝ **1-855-839-7613** (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր
- Մյուս բոլորը՝ **1-800-464-4000** (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր

Chinese：请注意。我们免费为您提供及时语言协助。您可以要求我们提供口译服务，包括手语翻译员。您可以要求将资料翻译成您所使用的语言或其他格式，如盲文版、音频版或大字版。您还可以要求在我们的设施使用语言辅助工具和设备。请致电会员服务部(Member Services)以获取帮助。会员服务部于重要节假日休息。

- 联邦医疗保险计划 (Medicare)，包括 D-SNP：**1-800-443-0815** (TTY **711**)，每周 7 天，上午 8:00 至晚上 8:00
- 加州医疗保健辅助计划：**1-855-839-7613** (TTY **711**)，每周 7 天，每天 24 小时
- 所有其他计划：**1-800-757-7585** (TTY **711**)，每周 7 天，每天 24 小时

Farsi: توجه. امکان بهره‌مندی به‌موقع و مقتضی از مساعدت زبانی به طور رایگان برای شما وجود دارد. می‌توانید خدمات ترجمه شفاهی را درخواست کنید، از جمله مترجمان زبان اشاره. همچنین می‌توانید مطالب ترجمه‌شده به زبان خودتان یا در قالب‌های جایگزین را درخواست کنید، از جمله خط بریل، فایل صوتی، یا چاپ با حروف درشت. همچنین می‌توانید امکانات و دستگاه‌های کمکی را از مراکز ما درخواست کنید. برای دریافت کمک، با بخش خدمات اعضای ما (Member Services) تماس بگیرید. بخش خدمات اعضا در تعطیلات رسمی تعطیل می‌باشد.

- Medicare، شامل D-SNP: با شماره **1-800-443-0815** (TTY **711**) از 8 صبح تا 8 عصر، در 7 روز هفته تماس بگیرید
- Medi-Cal: با شماره **1-855-839-7613** (TTY **711**)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید
- همه موارد دیگر: با شماره **1-800-464-4000** (TTY **711**)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید

Hindi: ध्यान दें। समय पर भाषा सहायता आपके लिए बिना किसी शुल्क के उपलब्ध है। आप दुभाषिया सेवाओं के लिए अनुरोध कर सकते हैं, जिसमें साइन लैंगुवेज के दुभाषिये भी शामिल हैं। आप सामग्रियों को अपनी भाषा या वैकल्पिक प्रारूप, जैसे कि ब्रेल, ऑडियो, या बड़े प्रिंट में अनुवाद करवाने के लिए भी कह सकते हैं। आप हमारे सुविधा-केंद्रों पर सहायक साधनों और उपकरणों का भी अनुरोध कर सकते हैं। सहायता के लिए हमारे सदस्य सेवा (Member Services) विभाग को कॉल करें। सदस्य सेवा विभाग मुख्य छुट्टियों वाले दिन बंद रहता है।

- Medicare, जिसमें D-SNP शामिल है: **1-800-443-0815** (TTY **711**), सुबह 8 बजे से रात 8 बजे तक, सप्ताह के 7 दिन
- Medi-Cal: **1-855-839-7613** (TTY **711**), दिन के चौबीस घंटे, सप्ताह के 7 दिन
- बाकी सभी: **1-800-464-4000** (TTY **711**), दिन के चौबीस घंटे, सप्ताह के 7 दिन

Hmong: CEEB TOOM. Sij hawm muaj kev pab txhais lus pub dawb rau koj. Koj muaj peev xwm thov kom pab txhais lus, suav nrog kws txhais lus piav tes. Koj muaj peev xwm thov kom muab cov ntaub ntawv no txhais ua koj yam lus los sis ua lwm hom, xws li hom ntawv rau neeg dig muag xuas, tso ua suab lus, los sis luam tawm kom koj. Koj kuj tuaj yeem thov kom muab tej khoom pab dawb thiab tej khoom siv txhawb tau rau

ntawm peb cov chaw kuaj mob. Hu mus thov kev pab rau ntawm peb Lub Chaw Pab Cuam Tswv Cuab. Lub Chaw Pab Cuam (Member Services) Tswv Cuab raug kaw rau cov hnub so tseem ceeb.

- Medicare, suav nrog D-SNP: **1-800-443-0815** (TTY **711**), 8 teev sawv ntxov txog 8 teev tsaus ntuj, 7 hnub hauv ib lub vij
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 teev hauv ib hnub, 7 hnub hauv ib lub vij
- Tag nrho lwm yam: **1-800-464-4000** (TTY **711**), 24 teev hauv ib hnub, 7 hnub hauv ib lub vij

Japanese：注意。タイムリーな言語サポートを無料でご利用いただけます。あなたは手話通訳を含む通訳サービスを依頼できます。点字、大型活字、または録音音声など、あなたの言語に翻訳された資料や別のフォーマットの資料を求めることができます。当社の施設では補助器具や機器の要請も承っております。支援が必要な方は、加入者サービス部門 (Member Services) にお電話ください。加入者向けサービスは、主要な休日には営業しておりません。

- D-SNP を含む Medicare: **1-800-443-0815** (TTY **711**)、午前 8 時から午後 8 時まで、年中無休
- Medi-Cal: **1-855-839-7613** (TTY **711**)、24 時間、年中無休
- その他全て: **1-800-464-4000** (TTY **711**)、24 時間、年中無休

Khmer (Cambodian): យកចិត្តទុកដាក់។
ជំនួយភាសាទាន់ពេលវេលាអាចរកបានដោយមិនគិតថ្លៃសម្រាប់អ្នក។
អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ រួមទាំងអ្នកបកប្រែភាសាសញ្ញាផងដែរ។
អ្នកអាចស្នើសុំឯកសារដែលត្រូវបានបកប្រែជាភាសារបស់អ្នក
ឬទម្រង់ផ្សេងទៀតដូចជាអក្សរស្ដាប សំឡេង ឬអក្សរធំៗ។ អ្នកក៏អាចស្នើសុំជំនួយបន្ថែម និងឧបករណ៍ជំនួយនៅតាមកន្លែងរបស់យើងផងដែរ។
សូមទូរសព្ទទៅផ្នែកសេវាសមាជិករបស់យើងសម្រាប់ជំនួយ។
សេវាកម្មសមាជិកត្រូវបានបិទនៅថ្ងៃឈប់សម្រាកសំខាន់ៗ (Member Services)។

- Medicare រួមទាំង D-SNP: **1-800-443-0815** (TTY **711**) ពីម៉ោង 8 ព្រឹក ដល់ 8 យប់ 7 ថ្ងៃក្នុងមួយសប្ដាហ៍
- Medi-Cal: **1-855-839-7613** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្ដាហ៍
- ផ្សេងៗទៀតទាំងអស់៖ **1-800-464-4000** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្ដាហ៍

Korean: 참고. 무료로 시기적절한 언어 지원을 제공합니다. 수화 통역사를 포함한 통역 서비스를 요청할 수 있습니다. 한국어로 번역된 자료 또는 점자, 오디오 또는 큰 글씨와 같은 대체 형식의 자료를 요청할 수 있습니다. 저희 시설에서 보조 기구와 장치를 요청할 수도 있습니다. 가입자 서비스 (Member Services) 부서에 전화하여 도움을 요청하십시오. 주요 공휴일에는 가입자 서비스를 운영하지 않습니다.

- Medicare(D-SNP 포함): 주 7 일 오전 8 시~오후 8 시에 **1-800-443-0815** (TTY **711**)번으로 문의
- Medi-Cal: **1-855-839-7613** (TTY **711**), 주 7 일, 하루 24 시간
- 기타 모두: **1-800-464-4000** (TTY **711**), 주 7 일, 하루 24 시간

Laotian: ຂໍ້ຄວນເອົາໃຈໃສ່. ມີການຊ່ວຍເຫຼືອດ້ານພາສາຢ່າງທັນເວລາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍບໍລິການລ່າມແປພາສາ, ລວມທັງລ່າມແປພາສາມື.
ທ່ານສາມາດຂໍເອກະສານທີ່ແປເປັນພາສາຂອງທ່ານ ຫຼື ຮູບແບບອື່ນ ເຊັ່ນ: ອັກສອນນູນ, ສຽງ ຫຼື ຕົວພິມໃຫຍ່. ນອກຈາກນີ້ ທ່ານຍັງສາມາດຮ້ອງຂໍເຄື່ອງຊ່ວຍເຫຼືອ ແລະ ອຸປະກອນເສີມໄດ້ທີ່ສະຖານທີ່ຍ່ານພະຍາບານຂອງພວກເຮົາ. ໂທຫາພະແນກການບໍລິການສະມາຊິກ (Member Services) ຂອງພວກເຮົາສຳລັບການຊ່ວຍເຫຼືອ. ການບໍລິການສະມາຊິກຈະປິດໃນວັນພັກສຳຄັນ.

- Medicare, ລວມທັງ D-SNP: **1-800-443-0815** (TTY **711**), 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ, 7 ມື້ຕໍ່ອາທິດ
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ
- ທັງໝົດອື່ນໆ: **1-800-464-4000** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ

Mien: MBUOX JANGX-FIM WAAC. Ninh mbuo duqv liepc ziangx tengx faan waac bun meih muangx hingh mv zuqc hoic meih ndortv nyaanh cingv oc. Meih corc haiv tov taux ninh mbuo tengx lorz faan waac bun meih, caux longc buoz wuv faan waac bun muangx. Meih aengx haih tov taux ninh mbuo dorh nyungc horngh jaa dorngx faan benx meih nyei waac a'fai fiev bieqc da'nyeic diuc daan, fiev benx domh nzangc-pokc bun hluo, bungx waac-qiez bun uangx, a'fai aamx bieqc domh zeiv-linh. Meih corc haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Mborqv finx lorz taux yie mbuo dinc zangc domh gorn ziux goux baengc mienh nyei dorngx liouh tov heuc ninh mbuo tengx nzie weih. Goux baengc mienh nyei dorngx duqv guon mv zoux gong yiem gingc nyei hnoi-nyieqc oc (Member Services).

- Medicare, caux D-SNP: **1-800-443-0815** (TTY **711**), yiem 8 dimv lungh ndorm taux 8 dimv lungh muonx, yietc norm leiz baaix zoux gong 7 hnoi
- Medi-Cal: **1-855-839-7613** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi
- Yietc zungv da'nyeic diuc jauv-louc: **1-800-464-4000** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi

Navajo: YÁ'ÁDÍÍŁTĮĮH. T'áá Bíní'dée'go Bizaad Bee Na'anish Bééhózin, Doo BéeNOLso Bee Na'al'a' Da. Tł'éé'góó tł'ízí'ígíí éí tséé' naalkáah sidá'ígíí bikáa' dah sidaaígíí, t'á'ii bik'eh dah na'ałkaígíí. T'á'ii éí tł'éé'góó tł'ízí'ígíí bik'eh dah deidiyós, t'á'ii éí bi'éé' bik'eh dah na'ałkaígíí bik'eh dah deidiyós. T'á'ii bik'eh dah na'ałkaígíí bikáa' dah na'ałkaígíí t'áá ałtso bik'eh dah deidiyós. Bi'éé' naalkáah sidá'ígíí bik'eh ha'a'aah. T'á'ii bik'eh dah na'ałkaígíí éí bik'eh dah naazhjaa'ígíí bik'eh dah na'ałkaígíí (Member Services).

- Medicare, 'ałdó' bii' hóló D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. góó 8 p.m., 7 jį t'ááłá'í damóo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 tł'ohch'oolí t'ááłá'í jį, 7 jį t'ááłá'í damóo
- T'áá ał'ąą: **1-800-464-4000** (TTY **711**), 24 tł'ohch'oolí t'ááłá'í jį, 7 jį t'ááłá'í damóo

Punjabi: ਧਿਆਨ ਦਿਓ। ਸਮੇਂ ਸਿਰ ਦਿੱਤੀ ਜਾਣ ਵਾਲੀ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ਿਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਿੱਤੇ ਜਾਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ, ਜਿਸ ਵਿੱਚ ਸਾਈਨ ਲੈਂਗੁਵੇਜ਼ ਦੇ ਦੁਭਾਸ਼ਿਏ ਵੀ ਸ਼ਾਮਲ ਹਨ। ਤੁਸੀਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ, ਜਾਂ ਕਿਸੇ ਵੈਕਲਪਿਕ ਫਾਰਮੈਟ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ, ਆਡੀਓ, ਜਾਂ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਅਨੁਵਾਦਿਤ ਕਰਨ ਲਈ ਵੀ ਕਹਿ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸਹੂਲਤਾਂ 'ਤੇ ਸਹਾਇਕ

ਏਡਜ਼ ਅਤੇ ਉਪਕਰਨਾਂ ਲਈ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ ਸਾਡੇ ਮੈਂਬਰਾਂ ਸੇਵਾਵਾਂ (Member Services) ਦੇ ਵਿਭਾਗ ਨੂੰ ਕਾੱਲ ਕਰੋ। ਮੈਂਬਰਾਂ ਸੇਵਾਵਾਂ ਦਾ ਵਿਭਾਗ ਮੁੱਖ ਛੁਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ।

- Medicare, ਬਜਸ ਬਵੱ D-SNP ਵੀ ਸ਼ਾਮਲ ਹੈ: **1-800-443-0815** (TTY **711**), ਸਵੇਰੇ 8 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8 ਵਜੇ ਤੱਕ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- Medi-Cal: **1-855-839-7613** (TTY **711**), ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- ਬਾਕੀ ਸਾਰੇ: **1-800-464-4000** (TTY **711**), ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ

Russian: ВНИМАНИЕ! Для Вас доступны бесплатные услуги перевода. Вы можете запросить услуги устного перевода, в том числе услуги переводчика языка жестов. Вы также можете запросить материалы, переведенные на ваш язык или в альтернативных форматах, например шрифтом Брайля, крупным шрифтом или в аудиоформате. Вы также можете запросить дополнительные приспособления и вспомогательные устройства в наших учреждениях. Если Вам нужна помощь, позвоните в отдел обслуживания участников. Отдел обслуживания участников (Member Services) не работает в дни государственных праздников.

- Medicare, включая D-SNP: **1-800-443-0815** (линия TTY **711**), ежедневно с 8:00 до 20:00.
- Medi-Cal: **1-855-839-7613** (линия TTY **711**), круглосуточно, ежедневно.
- Любые другие поставщики услуг: **1-800-464-4000** (линия TTY **711**), круглосуточно, ежедневно.

Spanish: ATENCIÓN. Se ofrece ayuda oportuna en otros idiomas sin ningún costo para usted. Puede solicitar servicios de interpretación, incluyendo intérpretes de lengua de señas. Puede solicitar materiales traducidos a su idioma o en formatos alternativos, como braille, audio o letra grande. También puede solicitar ayuda adicional y dispositivos auxiliares en nuestros centros de atención. Llame al Departamento de Servicio a los Miembros (Member Services) para pedir ayuda. Servicio a los Miembros está cerrado los días festivos principales.

- Medicare, incluyendo D-SNP: **1-800-443-0815** (TTY **711**), los 7 días de la semana, de 8 a. m. a 8 p. m., los 7 días de la semana
- Medi-Cal: **1-855-839-7613** (TTY **711**), las 24 horas del día, los 7 días de la semana.
- Todos los demás: **1-800-788-0616** (TTY **711**), las 24 horas del día, los 7 días de la semana.

Tagalog: ATENSYON. Ang napapanahong tulong sa wika ay makukuha nang walang bayad para sa iyo. Maaari kang humiling ng mga serbisyo ng interpreter, kasama ang mga interpreter sa sign language. Maaari kang humiling ng mga babasahin na nakasalin-wika sa iyong wika o sa mga alternatibong format, na tulad ng braille, audio, o malalaking titik. Puwede ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan ang aming departamento ng Mga Serbisyo sa Miyembro (Member Services) para sa tulong. Ang Mga Serbisyo sa Miyembro ay sarado sa mga pangunahing holiday.

- Medicare, kasama ang D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. hanggang 8 p.m., 7 araw sa isang linggo

- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo
- Ang lahat ng iba: **1-800-464-4000** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo

Thai: ส่งถึง มีบริการความช่วยเหลือด้านภาษาอย่างทันท่วงทีให้ท่านโดยไม่มีค่าใช้จ่าย ท่านสามารถขอรับบริการล่าม รวมถึงล่ามภาษามือได้ ท่านสามารถขอให้แปลเอกสารเป็นภาษาของท่าน หรือในรูปแบบอื่นๆ เช่นอักษรเบรลล์ ไฟล์เสียง หรือตัวอักษรขนาดใหญ่ ท่านสามารถขอรับอุปกรณ์ช่วยเหลือและอุปกรณ์เสริมได้ ณ สถานที่ให้บริการของเรา โทรติดต่อฝ่ายบริการสมาชิกของเรา (Member Services) เพื่อขอความช่วยเหลือได้ ฝ่ายบริการสมาชิกจะปิดทำการในวันหยุดราชการต่างๆ

- Medicare รวมถึง D-SNP: **1-800-443-0815** (TTY **711**) 8.00 น. ถึง 20.00 น.หรือ 7 วันต่อสัปดาห์
- Medi-Cal: **1-855-839-7613** (TTY **711**) ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์
- อื่นๆ ทั้งหมด: **1-800-464-4000** (TTY **711**) ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์

Ukrainian: УВАГА! Своєчасні послуги перекладача надаються безкоштовно. Ви можете залишити запит на послуги усного перекладу, зокрема мовою жестів. Ви можете зробити запит на отримання матеріалів, перекладених вашою мовою, або в альтернативних форматах, як-от надрукованим шрифтом Брайля чи великим шрифтом, а також у звуковому форматі. Крім того, ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Якщо вам потрібна допомога, зателефонуйте у відділ обслуговування клієнтів (Member Services). Відділ обслуговування клієнтів зачинений у державні свята.

- Medicare, зокрема D-SNP: **1-800-443-0815** (TTY **711**), із 8:00 до 20:00, без вихідних.
- Medi-Cal: **1-855-839-7613** (TTY **711**), цілодобово, без вихідних.
- Усі інші надавачі послуг: **1-800-464-4000** (TTY **711**), цілодобово, без вихідних.

Vietnamese: LƯU Ý. Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ kịp thời, miễn phí cho quý vị. Quý vị có thể yêu cầu dịch vụ thông dịch, bao gồm cả thông dịch viên ngôn ngữ ký hiệu. Quý vị có thể yêu cầu tài liệu được dịch sang ngôn ngữ của quý vị hay định dạng thay thế, chẳng hạn như chữ nổi braille, băng đĩa thu âm hay bản in khổ chữ lớn. Quý vị cũng có thể yêu cầu các phương tiện và thiết bị phụ trợ tại các cơ sở của chúng tôi. Gọi cho ban Dịch Vụ Hội Viên (Member Services) của chúng tôi để được trợ giúp. Ban Dịch Vụ Hội Viên không làm việc vào những ngày lễ lớn.

- Medicare, bao gồm cả D-SNP: **1-800-443-0815** (TTY **711**), 8 giờ sáng đến 8 giờ tối, 7 ngày trong tuần
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần
- Mọi chương trình khác: **1-800-464-4000** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần.

Nondiscrimination Notice

In this document, "we", "us", or "our" means Kaiser Permanente (Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., and the Southern California Medical Group). This notice is available on our website at **kp.org**.

Discrimination is against the law. We follow state and federal civil rights laws.

We do not discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services in a timely manner:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Services department at the numbers below. The call is free. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week.
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week.
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week.

Upon request, this document can be made available to you in braille, large print, audio, or electronic formats. To obtain a copy in one of these alternative formats, or another format, call our Member Services department and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Call our Member Services department. Phone numbers are listed above.
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at **kp.org/facilities** for addresses)

- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office for Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office for Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Office of Civil Rights
  Department of Health Care Services
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  California Department of Health Care Services Office for Civil Rights Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx

- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office for Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  U.S. Department of Health and Human Services Office for Civil Rights Complaint forms are available at: https://www.hhs.gov/ocr/office/file/index.html

- **Online:** Visit the **Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**