
KAISER PERMANENTE®
Healthy together
Care and coverage that fits your life

Welcome to care that fits your life

Your doctor, your choice

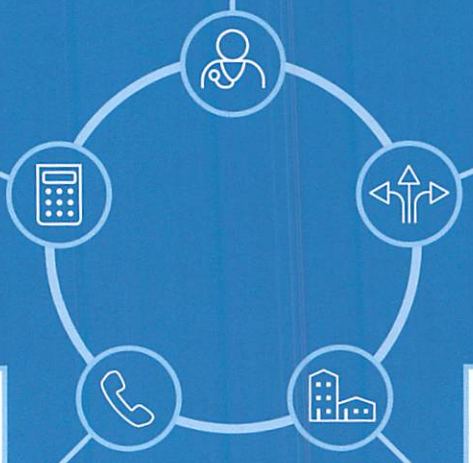
Choose your doctor based on what's important to you. Go to **kp.org/searchdoctors** for details about education, specialties, languages spoken, and more. You can also change doctors at any time.

Convenient cost estimates

Get an idea of what you'll pay before you come in for care. For a personalized estimate based on your plan details, visit **kp.org/costestimates**.

More care options

How you get care is up to you. Choose a phone or video appointment,[1] email your doctor's office with nonurgent questions, or come see us in person.[2]



Right care, right time

Get the care you need when you need it with routine, specialty, urgent, and emergency care. If you're ever unsure where to go, call us for 24/7 care advice by phone.

Many services under one roof

Do more in less time. In most of our facilities, you can see your doctor, get a lab test, and pick up prescriptions – all in a single trip.

[1]When appropriate and available.

[2]These features are available when you get care at Kaiser Permanente facilities.

Disclosure Form

115027 RIVERSIDE SHERIFFS ASSOCIATION BENEFIT
Home Region: Southern California

Principal benefits for Kaiser Permanente Traditional HMO Plan

(1/1/20—12/31/20)

Accumulation Period

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

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

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

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

Professional Services (Plan Provider office visits)	You Pay
Most Primary Care Visits and most Non-Physician Specialist Visits	$10 per visit
Most Physician Specialist Visits	$10 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	$10 per visit
Most physical, occupational, and speech therapy	$10 per visit

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Allergy injections (including allergy serum)	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge

Emergency Health Coverage	You Pay
Emergency Department visits	$50 per visit

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

Ambulance Services	You Pay
Ambulance Services	No charge

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items at a Plan Pharmacy	$5 for up to a 30-day supply
Most generic refills through our mail-order service	$10 for up to a 100-day supply
Most brand-name items at a Plan Pharmacy	$10 for up to a 30-day supply
Most brand-name refills through our mail-order service	$20 for up to a 100-day supply
Most specialty items at a Plan Pharmacy	$10 for up to a 30-day supply

Durable Medical Equipment (DME)	You Pay
DME items as described in the *EOC*	No charge

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$10 per visit
Group outpatient mental health treatment	$5 per visit

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	$10 per visit
Group outpatient substance use disorder treatment	$5 per visit

Home Health Services	You Pay
Home health care (up to 100 visits per Accumulation Period)	No charge

(continues)

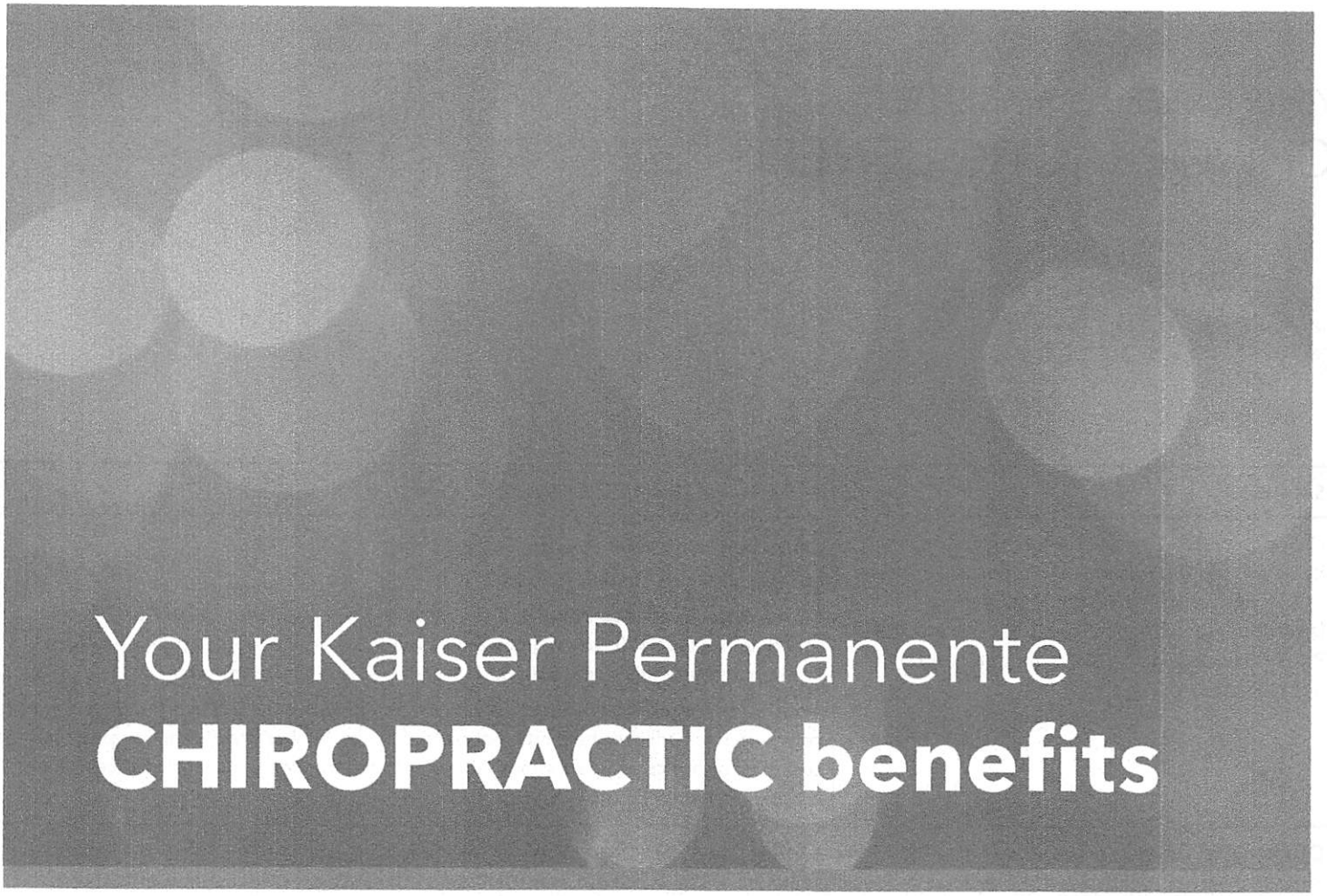
Disclosure Form

(continued)

Other	You Pay
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices as described in the *EOC*	No charge
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	50% Coinsurance
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Provided by American Specialty Health Plans of California, Inc. (ASH Plans)



Your Kaiser Permanente **CHIROPRACTIC benefits**

When you need chiropractic care, follow these simple steps:

1. Find an ASH Plans Participating Provider near you:
   - Go to **ashlink.com/ash/kp**, or
   - Call **1-800-678-9133** (TTY **711**), Monday through Friday, from 5 a.m. to 6 p.m. Pacific time
2. Schedule an appointment.
3. Pay for your office visit when you arrive for your appointment.

(See the reverse for more details.)

American Specialty Health Plans of California

KAISER PERMANENTE®

YOUR KAISER PERMANENTE

CHIROPRACTIC BENEFIT

Services	Cost Sharing and Office Visit Maximums
Chiropractic Services are covered when provided by a Participating Provider and medically necessary to treat or diagnose Neuromusculoskeletal Disorders. You can obtain services from any ASH Plans Participating Provider without a referral from a Plan Physician.	**Office visit cost share:** $5 copay per visit **Office visit limit:** 20 visits per year **Chiropractic appliance benefit:** If the amount of the appliance in the ASH Plans fee schedule exceeds $50, you will pay the amount in excess of $50, and that payment will not apply toward any applicable deductible or out-of-pocket maximum. Covered chiropractic appliances are limited to: elbow supports, back supports, cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units, ankle braces, knee braces, rib supports, and wrist braces.

Office visits: Covered Services are limited to Medically Necessary Chiropractic Services authorized and provided by ASH Plans Participating Providers except for Emergency Chiropractic Services and Services that are not available from Participating Providers or other licensed providers with which ASH contracts to provide covered care. Each office visit counts toward any visit limit, if applicable, even if an adjustment is not provided during the visit.

X-rays and laboratory tests: Medically necessary X-rays and laboratory tests are covered at no charge when prescribed as part of covered chiropractic care and a Participating Provider provides the Services or refers you to another licensed provider with which ASH contracts for the Services.

Participating Providers

ASH Plans contracts with Participating Providers and other licensed providers to provide covered Chiropractic Services, including laboratory tests, X-rays, and chiropractic appliances. You must receive covered services from a Participating Provider or another licensed provider with which ASH contracts, except for Emergency Chiropractic Services, Urgent Chiropractic Services, and services that are not available from Participating Providers or other licensed providers with which ASH contracts to provide covered Services that are authorized in advance by ASH Plans. The list of Participating Providers is available on the ASH Plans website at ashlink.com/ash/kp or from the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**), weekdays from 5 a.m. to 6 p.m. The list of Participating Providers is subject to change at any time without notice.

How to obtain services

To obtain covered services, call a Participating Provider to schedule an initial examination. If additional services are required, verification that the Services are Medically Necessary may be required. Your Participating Provider will request any medical necessity determinations. An ASH Plans clinician in the same or similar specialty as the provider of Services under review will decide whether the Services are or were Medically Necessary Services. ASH Plans will disclose to you, upon request, the process that it uses to authorize, modify, delay, or deny a request for authorization. If you have questions or concerns, please contact the ASH Plans Customer Service Department.

Second Opinions

You may request a second opinion in regard to covered Services by contacting another Participating Provider. A Participating Provider may also request a second opinion in regard to covered Services by referring you to another Participating Provider in the same or similar specialty.

Your Costs

When you receive covered Services, you must pay your Cost Share amount as described in the *Chiropractic Services Amendment* of your Health Plan *Evidence of Coverage.* The Cost Share does not apply toward the Plan Out-of-Pocket Maximum described in the Health Plan *Evidence of Coverage.*

Emergency and Urgent Chiropractic Services

We cover Emergency Chiropractic Services and Urgent Chiropractic Services provided by both Participating Providers and Non–Participating Providers. We do not cover follow-up or continuing care from a Non–Participating Provider unless ASH Plans has authorized the services in advance. Also, we do not cover services from a Non–Participating Provider that ASH Plans determines are not Emergency Chiropractic Services or Urgent Chiropractic Services.

Getting Assistance

If you have a question or concern regarding the services you received from an ASH Plans Participating Provider or another licensed provider with which ASH contracts, you may call ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**), weekdays from 5 a.m. to 6 p.m. Pacific time.

Grievances

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with Services you received. You may submit your grievance orally or in writing to Kaiser Permanente as described in your Health Plan *Evidence of Coverage.*

Exclusions and Limitations

- Services for asthma or addiction, such as nicotine addiction
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational services
- CT scans, MRIs, PET scans, bone scans, nuclear medicine, and any other types of diagnostic imaging or radiology other than X-rays covered under the "Covered Services" section of your *Chiropractic Services Amendment*
- Ambulance and other transportation
- Education programs, nonmedical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered in your *Chiropractic Services Amendment*
- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California except for Emergency Chiropractic Services and Urgent Chiropractic Services
- Hospital services, anesthesia, manipulation under anesthesia, and related services
- For Chiropractic Services, adjunctive therapy not associated with spinal, muscle, or joint manipulations
- Dietary and nutritional supplements, such as vitamins, minerals, herbs, herbal products, injectable supplements, and similar products
- Massage therapy
- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California
- Maintenance care (services provided to members whose treatment records indicate that they have reached maximum therapeutic benefit)

Definitions

ASH Plans: American Specialty Health Plans of California, Inc., a California corporation.

Chiropractic Services: Services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic appliances) for the treatment of your Neuromusculoskeletal Disorder.

Emergency Chiropractic Services: Covered Chiropractic Services provided for the treatment of a Neuromusculoskeletal Disorder which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a reasonable person could expect the absence of immediate Chiropractic Services to result in serious jeopardy to your health or body functions or organs.

Neuromusculoskeletal Disorders: Conditions with associated signs and symptoms related to the nervous, muscular, or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders, or biomechanical dysfunction of the joints of the body or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures), and related neurological manifestations or conditions.

Participating Provider: A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide Medically Necessary Chiropractic Services to you.

Urgent Chiropractic Services: Chiropractic Services that meet all of the following requirements:

- They are necessary to prevent serious deterioration of your health, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy.
- They cannot be delayed until you return to the Service Area.

This is only a summary and is intended to highlight only the most frequently asked questions about the benefit, including cost shares. Please refer to the *Chiropractic Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for a detailed description of the chiropractic benefits, including exclusions and limitations, Emergency Chiropractic Services, and Urgent Chiropractic Services.

Kaiser Foundation Health Plan, Inc. (Health Plan), contracts with American Specialty Health Plans of California, Inc. (ASH Plans), to make the ASH Plans network of Participating Providers available to you. You can obtain covered Services from any Participating Provider without a referral from a Plan Physician. Your Cost Share is due when you receive covered Services. Please see the definitions section of your *Chiropractic Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage* for terms you should know.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-678-9133 (TTY: 1-877-257-2746).

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-678-9133 (رقم هاتف الصم والبكم: 1-877-257-2746).

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-800-678-9133 (TTY (հեռատիպ)՝ 1-877-257-2746):

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-678-9133 (TTY: 1-877-257-2746) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-800-678-9133 (TTY: 1-877-257-2746) पर कॉल करें।

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-678-9133 (TTY: 1-877-257-2746).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-678-9133（TTY:1-877-257-2746）まで、お電話にてご連絡ください。

ប្រយ័ត្ន៖ បើអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ឥតគិតថ្លៃ គឺមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ 1-800-678-9133 (TTY: 1-877-257-2746)។

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-678-9133 (TTY: 1-877-257-2746)번으로 전화해 주십시오.

Díí baa akó nínízin: Díí saad bee yáníłti'go Diné Bizaad. saad bee áká'ánída'áwo'dęę', t'áá jiik'eh, éí ná hóló, koji' hódíilnih 1-800-678-9133 (TTY: 1-877-257-2746).

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹੈ। 1-800-678-9133 (TTY: 1-877-257-2746) 'ਤੇ ਕਾਲ ਕਰੋ।

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-678-9133 (телетайп: 1-877-257-2746).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-678-9133 (TTY: 1-877-257-2746).

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-800-678-9133 (TTY: 1-877-257-2746).

ข้อควรทราบ: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-678-9133 (TTY: 1-877-257-2746)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-678-9133 (TTY：1-877-257-2746) 。

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-678-9133 (TTY: 1-877-257-2746).

Experience the Kaiser Permanente difference

To be healthy, you need quality care that's simple, personalized, and hassle-free. At Kaiser Permanente, care and coverage come together – so you get everything you need to stay on top of your health in one easy-to-use package.

A stress-free path to switch plans

There's a lot to do when changing health plans. That's why we created a single destination that makes it easy to join Kaiser Permanente, and to get started once you do.

Ready for an easy switch? **It starts at kp.org/easyswitch.**

Let us help you find the right doctor

Finding a new doctor can feel stressful. But our online doctor profiles let you browse the many excellent doctors and convenient locations in your area, even before you enroll. So you can join knowing you've found a doctor who fits your needs. You're also free to change at any time, for any reason.

Transition your care seamlessly

Easily move prescriptions so your treatment is uninterrupted. And find a location that's close to your home, work, or school. Many services are often under one roof, making it easy to see your doctor, fill prescriptions, and get the care you need – all in one trip.

Get care on your schedule

Need to schedule an appointment? Have a nonurgent question you'd like to email to your doctor's office? After you enroll, register for an online account at **kp.org** or get our mobile app. Then join the millions of members who easily manage their health online – whenever, wherever.

Feel the healthy change – every step of the way

Whether you're unsure about changing doctors, have questions about a treatment plan, or are simply thinking about joining Kaiser Permanente, we're here to help. Call us at:

1-800-464-4000 (TTY **711**), 24 hours a day, 7 days a week (closed holidays)

Quality care with you at the center

Our physician-led care teams work together to keep you healthy by delivering high-quality, personalized care.

Great care from great doctors

Our doctors come from top medical schools, and many of them teach at world-renowned universities. No matter which personal doctor you choose, you'll be in highly skilled, experienced hands – and your health is their main concern.

As your biggest health advocate, your doctor will coordinate your care journey, and you'll work closely together to make decisions about your health.

Better care with a connected team

Your doctor, nurses, and other specialists all work together to keep you healthy. They're connected to each other, and to you, through your electronic health record. So they know important things about you and your health – like when you're due for a screening and what medications you're taking. That way, you get personalized care that's right for you.

Personalized care for all members

Care at Kaiser Permanente isn't one-size-fits-all. We believe your story, background, and values are as important as your health history. To help deliver care that's sensitive to your culture, ethnicity, and lifestyle, we:

- Strive to hire doctors and staff who speak more than one language
- Offer telephone interpretation services in more than 150 languages
- Train our care teams on how to connect with and care for people of diverse backgrounds

Through our culturally responsive care programs, we've improved health outcomes among diverse populations for conditions like high blood pressure, diabetes, and colon cancer.[1]

Great care, great results

From preventive screenings that keep you healthy to world-class care if you get sick, we've got you covered.

Preventive care to keep you healthy

Preventive care is key to how we practice medicine. It can help you avoid some health issues and catch others before they become serious.

Your electronic health record plays a vital role. It tracks your preventive care services and sends reminders when you're due for your next screening. We'll let you know when to come in so you're free to focus on living your life.

Specialty care when you need it

We're also here for you if you get sick or need specialty care. With one of the largest multispecialty medical groups in the country, we can conveniently connect you with the right specialist. And you don't need referrals for certain specialties, like obstetrics-gynecology, psychiatry, and drug dependency services.

From high-quality maternity care to treatment for cancer, heart problems, and more, you get great doctors, the latest technology, and evidence-based care – all combined to help you recover quickly.

Support for ongoing conditions

If you have a condition like diabetes or heart disease, you're automatically enrolled in a disease management program for personal coaching and support. With a well-rounded approach backed by proven best practices and advanced technology, we'll help you get the care you need to continue living life to the fullest.

A leader in clinical quality

In 2018, Kaiser Permanente led the nation as the top performer in 30 effectiveness-of-care measures – the most of any health plan.[2] These measures include:

- Prevention and screening
- Cardiovascular care
- Comprehensive diabetes care
- Medication monitoring

Hear care stories from real Kaiser Permanente members at **kp.org/carestories.**

Your care, your way

Get care where, when, and how you want it. With more options to choose from, it's easier to stay on top of your health.

Choose how you get care

In person	Visit your doctor for routine care, preventive services, care when you're not feeling well, and more. You may also be able to schedule same-day appointments.
Phone	Have a condition that doesn't require an in-person exam? Save yourself a trip to the office by scheduling a call with a Kaiser Permanente doctor.[3,4]
Video	Want a convenient, secure way to see a doctor wherever you are? Meet face-to-face online.[3,4] Call us or email your doctor's office to see if video visits are available to you.

Other ways to get care in the moment

24/7 care and advice by phone	Call us for advice when you need it most. We'll help you find out what care is right for you, schedule appointments, and more.
Email	Message your doctor's office anytime with nonurgent health questions.[4] You'll get a response usually within 2 business days.
Online	Manage your health, find nearby locations, and take advantage of health guides and other resources. You can also download the Kaiser Permanente app to keep up with your care on the go.[5]

Healthy resources

Good health goes beyond the doctor's office. Explore all the convenient resources available to members and choose the ones that fit your life.

Get the most out of your health plan

Online wellness tools	Visit **kp.org/healthyliving** for wellness information, health calculators, fitness videos, podcasts, and recipes from world-class chefs.
Healthy lifestyle programs	Connect to better health with online programs to help you lose weight, quit smoking, reduce stress, and more – all at no cost. Learn more at **kp.org/healthylifestyles**.
Health classes	Sign up for health classes and support groups at many of our facilities. See what's available near you at **kp.org/classes** – some may require a fee.
Personal wellness coaching	Get help reaching your health goals. Work one-on-one with a wellness coach by phone at no cost. Find out more at **kp.org/wellnesscoach**.
Special rates for members	Enjoy reduced rates on services that can help you stay healthy – like gym memberships, massage therapy, and more. Explore your options at **kp.org/choosehealthy**.
Seasonal farmers markets	Shop for local produce, fresh flowers, and more at farmers markets at many of our facilities. Learn more and find healthy recipes at **kp.org/foodforhealth**.

Care when and where you need it

It's easy for you and your family to get the care you need when you need it. There are many Kaiser Permanente facilities in your area, offering convenient hours and a wide range of care and services.

Convenient care near you

With multiple locations to choose from, it's easy to find one near home or work. We offer same-day, next-day, after-hours, and weekend services at many of our locations, along with ob-gyn, pediatrics, and other specialty departments. You can also see different doctors at different locations – whatever works best for you.

Finding the right location

Choosing a convenient place to get care is simple – just hop online or grab your smartphone.

- Visit **kp.org/facilities** to search by ZIP code, keyword, or the type of service you need.
- Search on your smartphone with the location finder on the Kaiser Permanente mobile app.[6]

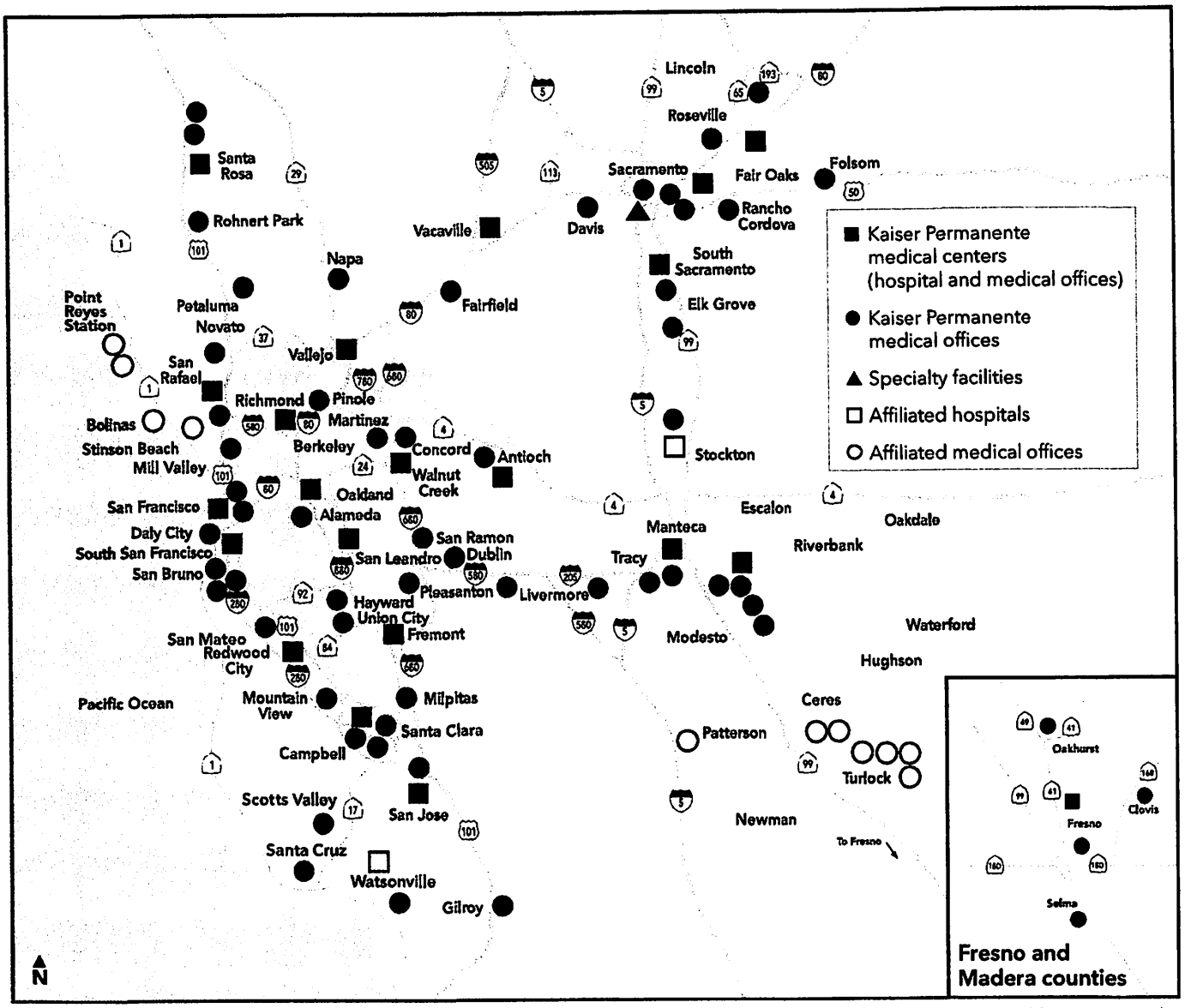
Getting care anytime, anywhere

Urgent care
Many facilities offer services for nonemergency, urgent medical needs that require immediate attention – open 7 days a week.[7]

Emergency care
If you ever need emergency care, you're covered. You can always get care at any Kaiser Permanente or non-Kaiser Permanente hospital emergency department.[8]

Care away from home
If you get hurt or sick while traveling, we'll help you get care. We can also help you before you leave town by checking to see if you need a vaccination, refilling prescriptions, and more. Just call our 24/7 Away from Home Travel Line[9] at **951-268-3900** or visit **kp.org/travel**.

See the following pages for location maps and a list of new medical facility openings in your area.



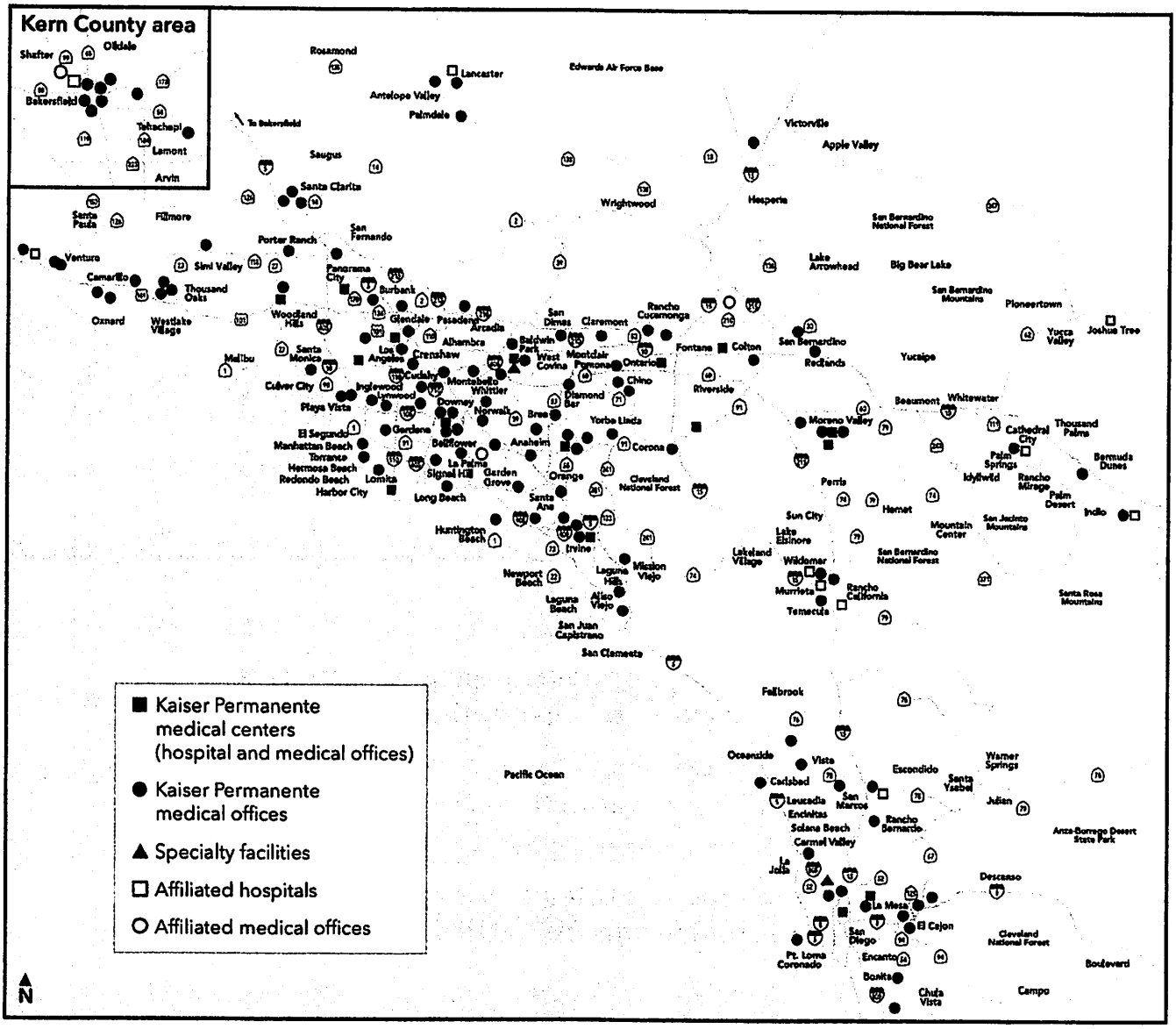
Maps not to scale

What's new in Northern California

Dublin Medical Offices:
New medical offices in Dublin offering a wide variety of specialty care services, with 24-hour urgent care center, cancer center with comprehensive oncology and infusion services, physical therapy, lab, ob-gyn, and more. Now open.

Mission Bay Sports Medicine Center:
New sports medicine center in San Francisco with state-of-the-art equipment and simulated sports rehabilitation environments for soccer, football, baseball, golf, and running. Will provide comprehensive care for diagnosis and treatment of injuries related to sports or recreational activities. Scheduled to open August 2019.

Roseville Medical Offices - Riverside:
New medical offices in Roseville with adult and family medicine, allergy/immunology, radiology, ophthalmology, and more. Scheduled to open fall 2019.



Maps not to scale

What's new in Southern California

Irwindale Medical Offices:
New medical offices in Irwindale with ambulatory surgery, gastroenterology, ophthalmology, podiatry, radiology, pharmacy, and lab. Now open.

Baldwin Park Medical Offices 2:
New medical offices in Baldwin Park with specialty care services including orthopedics, urology, rheumatology, and radiology. Scheduled to open end of 2019.

Porter Ranch Medical Offices:
New medical offices in Porter Ranch with primary and specialty care services including internal medicine, family medicine, pediatrics, ophthalmology, radiology, pharmacy, and lab. Scheduled to open July 2019.

Hollywood Romaine Medical Offices:
New medical offices in Los Angeles with primary and specialty care services including internal medicine, family medicine, pediatrics, ob-gyn, psychiatry, social medicine, radiology, pharmacy, and lab. Scheduled to open fall 2019.

Carson Medical Offices:
Expansion of Carson facility will include new mental health services, genetics, general surgery, pain management, podiatry, head and neck surgery, ophthalmology, urology, and rheumatology. Expansion scheduled to open in 2019.

Playa Vista Medical Offices:
In addition to current service offerings, relocation of the Playa Vista facility will include expanded services in mental health, occupational medicine, center for healthy living, and complete care nurse clinic. Scheduled to open in 2020.

Traditional HMO Plan

With this Kaiser Permanente health plan, you get a wide range of care and support to help you stay healthy and get the most out of life. Preventive care services – like routine physical exams, mammograms, and cholesterol screenings – are covered at no cost or at a copay,* and you pay just a copay for other services covered by your plan. For some specialty care, you don't even need a referral. For more details about your plan, see the *Disclosure Form Part Two* at the back of this book or ask your benefits manager for your *Evidence of Coverage*.

You pay copays or coinsurance for covered services, including prescriptions.

You don't have deductibles to keep track of.

You don't need a referral for certain specialties, like optometry and obstetrics-gynecology.

Preventive care services – like routine physical exams, mammograms, and cholesterol screenings – are covered at no cost or at a copay.*

Your out-of-pocket maximum helps limit how much you could spend for care each year.

*Depending on your plan, preventive care services are covered at no cost or at a copay. For more information, contact your employer.

Excellent care made easy

You get all the resources you need to stay in control of your health and your plan. We make it simple for you to know what to expect and to get high-quality care for your needs. For your specific copay, coinsurance, and out-of-pocket maximum amounts, see the *Disclosure Form Part One* at the front of this book or ask your benefits manager for your *Evidence of Coverage*.

Limits on how much you pay for care

For covered services, you'll pay one set amount – your copay. Copays keep things simple and make it easy to know what to expect. For some supplemental services, like infertility treatments, you'll pay a percentage of the charges – what's called a coinsurance.

You also have an out-of-pocket maximum. It helps limit how much you'll pay for care. If you reach your maximum, you won't pay for covered services for the rest of the year. This helps protect you financially if you ever get seriously sick or injured. For a small number of services, you may keep paying copays or coinsurance after reaching your out-of-pocket maximum.

No deductibles

For many types of routine care, including doctor's office visits and inpatient hospitalization, you'll pay just a copay. Your copays may be higher for inpatient hospitalization and emergency care, but emergency care copays are waived if you're admitted to the hospital.

Prescription drug coverage

Your generic, brand-name, and specialty prescription drugs are covered at a copay or coinsurance when you fill your prescriptions at our pharmacies. See the *Disclosure Form Part One* at the front of this book for details on your prescription coverage.

To fill your prescription, simply visit one of our pharmacies, which are conveniently located at most Kaiser Permanente facilities. For refills, you can order:

- Online or on the Kaiser Permanente app
- By phone
- By mail
- In person

Copay

A set amount you pay for covered services.

Example: $20 for an office visit and $10 for generic prescription drugs.

Coinsurance

A percentage of the charges that you pay for covered services.

Example: 20% coinsurance for a $200 outpatient procedure = $40.

Out-of-pocket maximum

The maximum amount you'll pay for covered services each year. For a small number of services, you may need to keep paying copays or coinsurance after reaching your out-of-pocket maximum.

Example: If you have a $1,000 out-of-pocket maximum and you reach it before the year's up, you'll pay no charges for most covered services for the rest of the year.

For more information, including resources for understanding your costs, visit kp.org/ca/hmo.

A plan for healthy living

Know what to expect, then jump in with both feet. Your plan helps keep your costs under control, and you get useful tools that help you understand when and how much you can expect to pay. This makes it easier for you to manage your care and get the most out of your plan.

Know before you go

Knowing how your plan works can give you a better idea of how much you'll pay when you get care. Once you're a member, you can register on our website to use our Estimates tool, which can help you get an idea of the costs of services you're scheduled to receive. You can also use the Estimates tool to see how close you are to reaching your out-of-pocket maximum.

Billing for additional services

When you come in for care, you'll pay a copay or coinsurance for your scheduled services. If you get additional services during your visit, you'll get a bill later for any copays or coinsurance you owe.

Care away from home

If you get hurt or sick while traveling, we'll help you get care. We can also help you before you leave town by checking to see if you need to get vaccinations, refill prescriptions, and more. Just call our 24/7 Away from Home Travel Line* at **951-268-3900** or visit **kp.org/travel**.

*This number can be dialed inside and outside the United States. Before the phone number, dial "001" for landlines and "+1" for mobile lines if you're outside the country. Long-distance charges may apply, and we can't accept collect calls. The phone line is closed on major holidays (New Year's Day, Easter, Memorial Day, July Fourth, Labor Day, Thanksgiving, and Christmas). It closes early the day before a holiday at 10 p.m. Pacific time (PT), and it reopens the day after a holiday at 4 a.m. PT.

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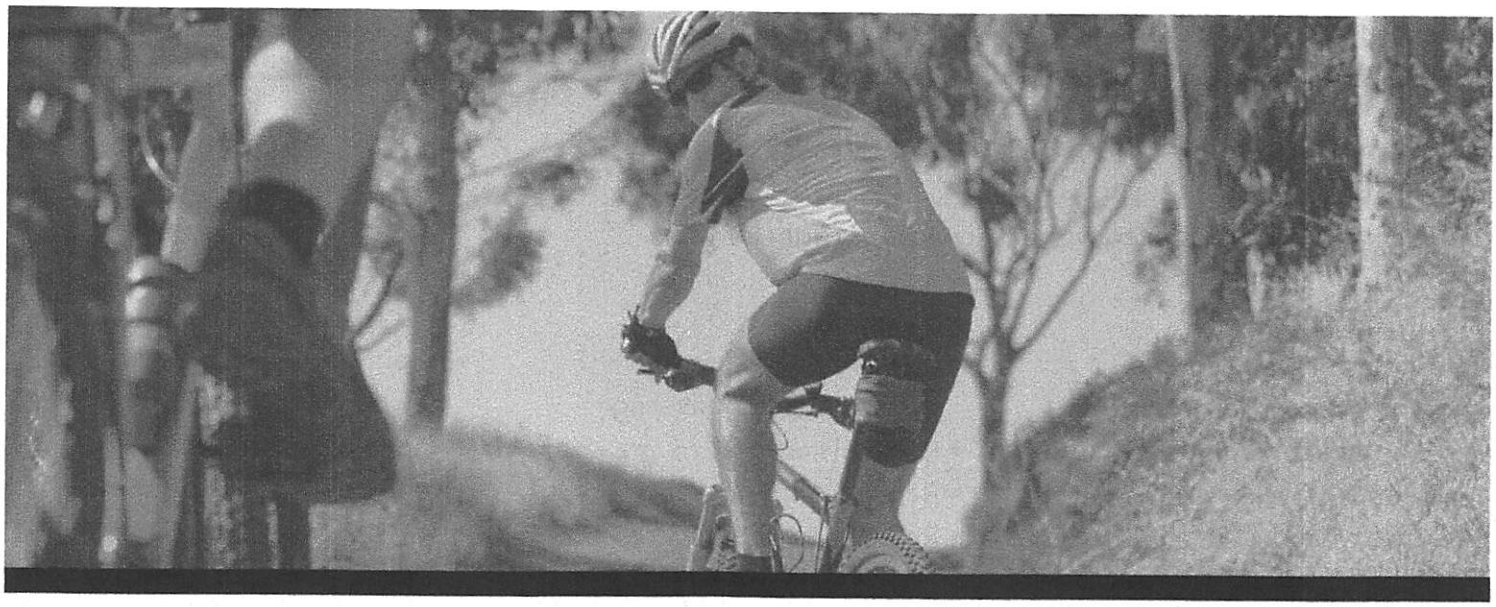

Understanding your costs during preventive care visits

You get preventive care services at no cost or at a copay, depending on your plan. During a preventive care visit, you might find out that you need non-preventive services to treat a condition or test for a problem. If that happens, you might have extra costs. Understanding the difference between preventive and non-preventive care can help you know what's covered and when you might get a bill.

Preventive care is covered at no cost or at a copay

The purpose of preventive care is to help keep you healthy and find problems early. Examples include routine checkups, preventive screenings, and immunizations.

➪ Look on the back for a list of common preventive care services.

Non-preventive care may come with an additional cost

Tests and procedures to diagnose or treat health problems are considered non-preventive, so you may get a bill for them later.* Here are some examples of non-preventive care you could receive during a preventive care visit:

Discussing new symptoms

If you ask your doctor to look at a rash, they might **diagnose the problem.** You may get a bill for an office visit and any treatment you needed.

Unplanned procedures

If your doctor finds a suspicious mole, they may remove it and have it tested. You'll be charged for the **procedure** to remove the mole, and for the test.

Treatment or testing for existing conditions

If you're taking a new medication, your doctor might order a **lab test** to see if it's working and make sure you're on the right dose.

Treatment or testing for new conditions

If you complain of knee pain, your doctor might order an **X-ray** to see if you have an injury that needs to be treated.

*See your *Evidence of Coverage*, *Summary Plan Description*, or other plan documents for information on your benefit coverage.

KAISER PERMANENTE®

Common preventive care services

Different people have different preventive care needs. Talk to your doctor about which preventive care services are right for you.

For all adults

- Cholesterol screenings
- Colon cancer screenings
- Diabetes screenings
- Routine physical exams
- Immunizations
- Family planning services, including (but not limited to):
  - Contraceptive and family planning counseling
  - Contraceptive devices and drugs

For women

- Breastfeeding support, supplies, and counseling
- Prenatal care
- Routine mammograms
- Routine Pap tests

For children

- Hearing screening for newborns
- Immunizations
- Periodic well-child visits
- Sexually transmitted infection (STI) screenings and prevention counseling for adolescents
- Vision screenings

Visit **kp.org/prevention** for a complete list of preventive services.

How do I pay for non-preventive services?

You'll usually get a bill in the mail later. However, in some cases you may need to pay for unscheduled non-preventive services during your visit.

Have questions about your costs or bills?

Call **1-800-464-4000,** 24 hours a day, 7 days a week (closed holidays). For TTY, call **711.**
We also offer options like payment plans and financial assistance for members who qualify.

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

Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, materials translated into your language, or in alternative formats. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Spanish: Contamos con asistencia de idiomas sin costo alguno para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al **711**.

Chinese: 您每週 7 天，每天 24 小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。我們每週 7 天，每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日 休息）。聽障及語障專線 (TTY) 使用者請撥 **711**。

KAISER PERMANENTE®

Please recycle. 60853408 December 2017

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

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

Your Health Plan Coverage

Member Service Contact Center
24 hours a day, 7 days a week
(except closed holidays)
1-800-464-4000 toll free
711 (TTY)
kp.org

61138512

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, materials translated into your language, or in alternative formats. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: خدمات الترجمة الفورية متوفرة لك مجانًا على مدار الساعة كافة أيام الأسبوع. بإمكانك طلب خدمة الترجمة الفورية أو ترجمة وثائق للغتك أو لصيغ أخرى. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمة الهاتف النصي يرجي الاتصال على الرقم (**711**).

Armenian: Ձեզ կարող է անվճար օգնություն տրամադրվել լեզվի հարցում՝ օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Պարզապես զանգահարեք մեզ՝ **1-800-464-4000** հեռախոսահամարով՝ օրը 24 ժամ՝ շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711**:

Chinese: 您每週 7 天，每天 24 小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。我們每週 7 天，每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日 休息）。聽障及語障專線 (TTY) 使用者請撥 **711**。

Farsi: خدمات زبانی در 24 ساعت شبانروز و 7 روز هفته بدون اخذ هزینه در اختیار شما است. شما می توانید برای خدمات مترجم شفاهی، ترجمه جزوات به زبان شما و یا به صورتهای دیگر درخواست کنید. کافیست در 24 ساعت شبانروز و 7 روز هفته (به استثنای روزهای تعطیل) با ما به شماره **1-800-464-4000** تماس بگیرید. کاربران TTY با شماره **711** تماس بگیرند.

Hindi: बिना किसी लागत के दुभाषिया सेवाएँ, दिन के 24 घंटे, सप्ताह के सातों दिन उपलब्ध हैं। आप एक दुभाषिये की सेवाओं के लिए, बिना किसी लागत के सामग्रियों को अपनी भाषा में अनुवाद करवाने के लिए, या वैकल्पिक प्रारूपों के लिए अनुरोध कर सकते हैं। बस केवल हमें **1-800-464-4000** पर, दिन के 24 घंटे, सप्ताह के सातों दिन (छुट्टियों वाले दिन बंद रहता है) कॉल करें। TTY उपयोगकर्ता **711** पर कॉल करें।

Hmong: Muajkwc pab txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom.Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu **711**.

Japanese: 当院では、言語支援を無料で、年中無休、終日ご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは資料を別の書式でも依頼できます。お気軽に **1-800-464-4000** までお電話ください（祭日を除き年中無休）。TTY ユーザーは **711** にお電話ください。

Khmer: ជំនួយភាសា គឺមានឥតអស់ថ្លៃជូនអ្នកឡើយ 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ សំភារៈដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទំរង់ផ្សេងទៀត។ គ្រាន់តែទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិត្យ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ 711។

Korean: 요일 및 시간에 관계없이 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스, 귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000** 번으로 전화하십시오 (공휴일 휴무). TTY 사용자 번호 **711**.

Laotian: ການຊ່ວຍເຫຼືອດ້ານພາສາມີໃຫ້ໂດຍບໍ່ເສັງຄ່າ ແກ່ທ່ານ, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ. ທ່ານ ສາມາດຮ້ອງຂໍຮັບບໍລິການນາຍພາສາ, ໃຫ້ແປເອກະ ສານເປັນພາສາຂອງທ່ານ, ຫຼື ໃນຮູບແບບອື່ນ. ພຽງ ແຕ່ໂທຫາພວກເຮົາທີ່ **1-800-464-4000**, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ (ປິດວັນພັກຕ່າງໆ). ຜູ້ໃຊ້ສາຍ TTY ໂທຣ **711**.

Navajo: Saad bee áká'a'ayeed náhóló t'áá jiik'é, naadiin doo bibąą' dįį' ahéé'iikeed tsosts'id yiskąąjį damoo ná'ádleehjį. Atah halne'é áká'adoolwołígíí jóki, t'áadoo le'é t'áá hóhazaadjį hadilyąą'go, éí doodaii' nááná lá ał'ąą ádaat'ehígíí bee hádadilyaa'go. Kojį hodiilnih **1-800-464-4000**, naadiin doo bibąą' dįį' ahéé'iikeed tsosts'id yiskąąjį damoo ná'ádleehjį (Dahodiyin biniiyé e'e'aahgo éí da'deelkaal). TTY chodeeyoolínígíí kojį hodiilnih **711**.

Punjabi: ਬਿਨਾਂ ਕਿਸੀ ਲਾਗਤ ਦੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਦਿਨ, ਦੁਭਾਸ਼ੀਆ ਸੇਵਾਵਾਂ ਤੁਹਾਡੇ ਲਈ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਇੱਕ ਦੁਭਾਸ਼ੀਏ ਦੀ ਮਦਦ ਲਈ, ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਅਨੁਵਾਦ ਕਰਵਾਉਣ ਲਈ, ਜਾਂ ਕਿਸੇ ਵੱਖ ਫਾਰਮੈਟ ਵਿੱਚ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਬਸ ਸਿਰਫ਼ ਸਾਨੂੰ **1-800-464-4000** ਤੇ, ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ (ਛੁੱਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ) ਫ਼ੋਨ ਕਰੋ। TTY ਦਾ ਉਪਯੋਗ ਕਰਨ ਵਾਲੇ **711** 'ਤੇ ਫ਼ੋਨ ਕਰਨ।

Russian: Мы бесплатно обеспечиваем Вас услугами перевода 24 часа в сутки, 7 дней в неделю. Вы можете воспользоваться помощью устного переводчика, запросить перевод материалов на свой язык или запросить их в одном из альтернативных форматов. Просто позвоните нам по телефону **1-800-464-4000**, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру **711**.

Spanish: Contamos con asistencia de idiomas sin costo alguno para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al **711**.

Tagalog: May magagamit na tulong sa wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo. Maaari kang humingi ng mga serbisyo ng tagasalin sa wika, mga babasahin na isinalin sa iyong wika o sa mga alternatibong format. Tawagan lamang kami sa **1-800-464-4000**, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa **711**.

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

Vietnamese: Dịch vụ thông dịch được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. Quý vị chỉ cần gọi cho chúng tôi tại số **1-800-464-4000**, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi **711**.

Nondiscrimination Notice

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

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

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

You may submit a grievance in the following ways:

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

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

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

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

Introduction

About the *Disclosure Form*

This *Disclosure Form* summarizes some of the important features of your Kaiser Permanente membership, as well as general exclusions and limitations of your coverage. **PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY OBTAIN HEALTH CARE.** Also, you should read this *Disclosure Form* and the *Evidence of Coverage* ("EOC") carefully if you have special health care needs.

When you join Kaiser Permanente, you are enrolling in 1 of 2 Health Plan Service Areas in California (the Northern California or Southern California Region), which we call your "Home Region."

Please refer to *Your Benefits (Disclosure Form Part One)* to learn which California Region is your Home Region. This *Disclosure Form* describes your coverage in your Home Region.

The Services described under *Your Benefits (Disclosure Form Part One)* are covered only if all of the following conditions are satisfied:

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

Also, this *Disclosure Form* describes different benefit plans; for example, benefit plans that may include deductibles for specified Services. Everything in this section of the *Disclosure Form* applies to all benefit plans, except as otherwise indicated.

Please see *Your Benefits (Disclosure Form Part One)* for a summary of deductibles, Copayments, and Coinsurance. If you have questions about benefits, please call our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**) or refer to the *EOC*.

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

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

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

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

How to obtain Services

Our Members receive covered medical care from Plan Providers (physicians, registered nurses, nurse practitioners, and other medical professionals) inside your Home Region's Service Area at Plan Facilities except as described in this *Disclosure Form* or the *EOC* for the following Services listed below:

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

Visiting Member Services

For Plan Facility locations, please refer to the facility listing, on our website at **kp.org/facilities**, or call our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**).

Emergency Services

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

Emergency Services are available from Plan Hospital Emergency Departments 24 hours a day, 7 days a week.

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

To request prior authorization the Non-Plan Provider must call the notification

telephone number on your Kaiser Permanente ID card *before* you receive the care. Be sure to ask the Non-Plan Provider to tell you what care (including any transportation) we have authorized since we do 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.

Please refer to the *EOC* for coverage information, exclusions, and limitations.

Urgent Care

Inside your Home Region Service Area. If you think you may need Urgent Care, call the appropriate appointment or advice nurse telephone number at a Plan Facility.

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

You do not need prior authorization for Out-of-Area Urgent Care.

To obtain follow-up care from a Plan Provider, call the appointment or advice telephone number at a Plan Facility. We do not cover follow-up care from Non-Plan Providers after you no longer need Urgent Care, except for covered durable medical equipment. If you require durable medical equipment related to your Urgent Care after receiving Out-of-Area Urgent Care, your provider must obtain prior authorization.

Your ID card

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

If you need to get care before you receive your ID card, please ask your group for your group (purchaser) number and the date your coverage became effective.

Plan Facilities and *Your Guidebook to Kaiser Permanente Services (Your Guidebook)*

At most of our Plan Facilities, you can usually receive all the covered Services you need, including Emergency Services, Urgent Care, specialty care, pharmacy, and laboratory tests. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you. For a listing of facility locations in your area, please visit our website at **kp.org/facilities** or call our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**).

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, 7 days a week
- Emergency Services are available at Plan Hospital Emergency Departments listed in *Your Guidebook* (please refer to *Your Guidebook* or the facility directory on our website at **kp.org** for Emergency Department locations in your area)
- Same day Urgent Care appointments are available at many locations (please refer to *Your Guidebook* or the facility directory on our website at **kp.org** for Urgent Care locations in your area)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for locations in your area)

Plan Medical Offices and Plan Hospitals for your area are listed in detail in *Your Guidebook to Kaiser Permanente Services* (*Your Guidebook*) and on our website at **kp.org**. *Your Guidebook* describes the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. *Your Guidebook* also explains how to use our Services and make appointments, lists hours of operations, and includes a detailed telephone directory for appointments and advice. *Your Guidebook* provides other important information, such as preventive care guidelines and your Member rights and responsibilities. *Your Guidebook* is subject to change and is periodically updated. You can get a copy by visiting our website at **kp.org** or by calling our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**), 24 hours a day, 7 days a week (except closed holidays).

Your personal Plan Physician

Personal Plan Physicians 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 who 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. You can change your personal Plan Physician at any time for any reason. To learn how to select a personal Plan Physician, please call our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**). You can find a directory of our Plan Physicians on our website at **kp.org**.

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 care from Qualified Autism Service Providers covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the *EOC*. 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 "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section.
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition.

Standing referrals

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

Medical Group authorization procedure for certain referrals

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

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

Utilization Management (UM) is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at **kp.org/UM** or call our Member Service Contact Center to request a printed copy. Please refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section of your *EOC* for authorization requirements that apply to Post-Stabilization Care from Non-Plan Providers.

Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals. This description is only a brief summary of the authorization procedure. For more information, please refer to the *EOC* or call our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**).

Second opinions

You have the right to a second opinion. If you want a second opinion, you can ask Member Services to help you arrange one with another Plan Physician who is an appropriately qualified medical professional for your condition. For more information, please refer to the *EOC*.

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: within 48 hours

- Nonurgent Primary Care Visit or Non-Physician Specialist Visit: within 10 business days
- Physician Specialist Visit: within 15 business days

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

How Plan Providers are paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital care for Members, please visit our website at **kp.org** or call our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**).

Your costs

Cost Share (deductibles, Copayments, and Coinsurance)

When you receive covered Services, you must pay the Cost Share amount listed in the *EOC*. In most cases, your provider will ask you to make a payment toward your Cost Share at the time you receive Services. Keep in mind that this payment may cover only a portion of your total Cost Share for the covered Services you receive, and you will be billed for any additional amounts that are due. 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 any Cost Share amounts that are due. The following are examples of when you may get a bill:

- You receive non-preventive Services during a preventive visit
- You receive diagnostic Services during a treatment visit
- You receive treatment Services during a diagnostic visit.
- You receive Services from a second provider during your visit
- A Plan Provider is not able to collect Cost Share at the time you receive Services
- You ask to be billed for some or all of the Cost Share
- Medical Group authorizes a referral to a Non-Plan Provider and the provider does not collect Cost Share at the time you receive Services
- You receive covered Emergency Services or Out-of-Area Urgent Care from a Non-Plan Provider and that provider does not collect your Cost Share at the time you receive Services

In some cases, a Non-Plan Provider may be involved in the provision of covered Services 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 Services 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, please see the "Post-Service Claims and Appeals" section.

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

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call weekdays 7 a.m. to 7 p.m. toll free at **1-800-390-3507** (TTY users call **711**). Refer to *Your Benefits (Disclosure Form Part One)* to find out if you have a Plan Deductible.
- For all other Cost Share estimates, please call **1-800-464-4000** (TTY users call **711**), 24 hours a day, 7 days a week (except 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.

Copayments and Coinsurance

A summary of Copayments and Coinsurance is listed in *Your Benefits (Disclosure Form Part One)*. Please refer to the *EOC* for the complete list of Copayments and Coinsurance.

After you meet any applicable deductible and for the remainder of that Accumulation Period, you pay the applicable Copayment or Coinsurance, subject to the Plan Out-of-Pocket Maximum.

Drug Deductible

If your coverage includes a Drug Deductible, the deductible limits will be specified in *Your Benefits (Disclosure Form Part One)*. If you have a Drug Deductible, you must pay Charges for Services subject to the Drug Deductible during the Accumulation Period for certain drugs, supplies and supplements until you meet the Drug Deductible amount listed in *Your Benefits (Disclosure Form Part One)*. Once you meet the Drug Deductible, we will cover those Services at the applicable Copayment or Coinsurance amount. Please refer to "Outpatient Prescription Drugs, Supplies, and Supplements" section of the *EOC* for Services that are subject to the Drug Deductible.

Plan Deductible

If your coverage includes a Plan Deductible, the deductible limits will be specified in *Your Benefits (Disclosure Form Part One)*. If you have a Plan Deductible, you must pay Charges for Services subject to the Plan Deductible until you meet the Plan Deductible each Accumulation Period. The only payments that count toward a Plan Deductible are those you make for covered Services that are subject to the Plan Deductible. The Plan Deductible is for the calendar year unless a different Accumulation Period is specified in *Your Benefits (Disclosure Form Part One)*.

When the Copayment or Coinsurance for a particular Service is described as "after Plan Deductible" in *Your Benefits (Disclosure Form Part One)* you must pay Charges for those Services until you meet the deductible. Please refer to the *Evidence of Coverage* for more information about which Services are subject to the Plan Deductible and an explanation of how the deductible works.

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

Plan Out-of-Pocket Maximum

The Plan Out-of-Pocket Maximum is the total amount of Cost Share you must pay in the Accumulation Period for covered Services that you receive in the same Accumulation Period. Please refer to the *Your Benefits (Disclosure Form Part One)* to find your Plan Out-of-Pocket Maximum. The Accumulation Period is the calendar year unless a different Accumulation Period is specified in *Your Benefits (Disclosure Form Part One)*. Please refer to the *EOC* to learn which Services apply to the Plan Out-of-Pocket Maximum.

Payment of Premiums

Your group is responsible for paying Premiums, except that you are responsible for paying Premiums if you have Cal-COBRA coverage. If you are responsible for any contribution to the Premiums that your group pays, your group will tell you the amount, when Premiums are effective, and how to pay your group (through payroll deduction, for example).

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 cost of noncovered Services you obtain from Plan Providers or Non-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for the covered Services you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. In some cases, you may be eligible to receive Services from a terminated provider in accord with applicable law.

Please refer to "Completion of Services from Non-Plan Providers in the "Miscellaneous notices" section for more information.

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

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non-Plan Provider, or if you receive emergency ambulance Services, you are not responsible for any amounts beyond your Cost Share. We will reduce any payment we make to you or the Non-Plan Provider by any applicable Cost Share. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement.

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

- As soon as possible, obtain a claim form by:
  - calling our Member Service Contact Center toll free at **1-800-464-4000** or **1-800-390-3510** (TTY users call **711**), or
  - through our website at **kp.org**

One of our representatives will be happy to assist you if you need help completing our claim form

- If you have paid for Services, you must send us our completed claim form for reimbursement. Please attach any bills and receipts from the Non-Plan Provider
- To request that a Non-Plan Provider be paid for Services, you must send us our completed claim form and include any bills from the Non-Plan Provider. If the Non-Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the Non-Plan Provider for covered Services other

than your Cost Share amount, please call our Member Service toll free at **1-800-390-3510** for assistance

- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled. For example, we may require documents such as travel documents or verification of your travel or itinerary.

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

Termination of benefits

Your group is required to inform the Subscriber of the date your membership terminates except as otherwise noted. You will be billed as a non-Member for any Services you receive after your membership terminates.

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

- The contract between your group and Kaiser Permanente is terminated for any reason
- You are no longer eligible for group coverage
- You intentionally commit fraud in connection with membership, Health Plan or a Plan Provider (if you intentionally commit fraud, 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). 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
- Your group fails to pay Premiums for your Family (or if your Family fails to pay Premiums for Cal-COBRA coverage for your Family)

Please refer to the *EOC* for more information.

Continuation of membership

Continuation of group coverage

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

If at any time you become entitled to continuation of group coverage such as Cal-COBRA, please examine your coverage options carefully before declining this coverage. Under the Affordable Care Act, individual plan coverage is available without medical review. However, the individual plan premiums and coverage are different from the premiums and coverage under your group plan.

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

Individual Plan

If you want to remain a Health Plan member when your group coverage ends, you can enroll in one of our plans for individuals and families. The premiums and coverage under our individual plan coverage are different from those under your group coverage.

If you want your individual plan coverage to be effective when your group coverage ends, you must submit your application within the special enrollment period for enrolling in an individual plan due to loss of other coverage. Otherwise, you will have to wait until the next annual open enrollment period.

To request an application to enroll directly with us, please go to **kp.org** or call our Member Service Contact Center. For information about plans that are available through Covered California, visit **CoveredCA.com** or call Covered California at **1-800-300-1506** (TTY users call **711**).

Getting assistance

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

Member Services

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

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

You can reach Member Services in the following ways:

Call:
1-800-464-4000 (English 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, 7 days a week (except closed holidays)

Visit:
Member Services Department at a Plan Facility (refer to *Your Guidebook* or the

facility directory on our website at **kp.org** for addresses)

Write:
Member Services Department at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for addresses)

Website:
kp.org

Dispute resolution and binding arbitration

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

Independent medical review is available if you believe that we improperly denied, modified, or delayed Services or payment of Services, and that either (1) our denial was based on a finding that the Services are not Medically Necessary, or (2) for life-threatening or seriously debilitating conditions, the requested treatment was denied as experimental or investigational. Also, if you should file a grievance and you later need help with it because your grievance is an emergency, it hasn't been resolved to your satisfaction, or it's unresolved after 30 days, you may call the California Department of Managed Health Care toll free at **1-888-HMO-2219** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired for assistance.

Except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law, any dispute between Members, their heirs, or associated parties (on the one hand) and Health Plan, its health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising from your Health Plan membership, must be decided through binding arbitration. This includes claims for medical or hospital malpractice (a claim that medical services 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, regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration.

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

Renewal provisions

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

Principal exclusions, limitations, and reductions of benefits

Exclusions

The following are the principal exclusions from coverage. See the *EOC* for the complete list, including details and any exceptions to the exclusions. Also, additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the *EOC*. These exclusions or limitations do not apply to Services that are Medically Necessary to treat Severe Mental Illness or Serious Emotional Disturbance of a Child Under Age 18.

- Care in a residential care facility except for Services covered under "Substance Use Disorder Treatment" and "Mental Health Services" in the *EOC*
- Care in an intermediate care facility, unless otherwise stated in the *EOC*
- Chiropractic Services, unless otherwise stated in the *EOC*
- Cosmetic Services, except for Services covered under "Reconstructive Surgery" and "Prosthetic and Orthotic Devices" in the *EOC*
- Custodial care, except for covered hospice care
- Dental and orthodontic Services and X-rays, except for Services covered under "Dental and Orthodontic Services" in the *EOC*
- Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies
- Experimental or investigational Services, except as required by law for certain clinical trials. You can request an independent medical review if you disagree with our decision to deny treatment because it is experimental or investigational (please refer to the *EOC* for details about independent medical review and other dispute resolution options)
- Hearing aids, unless otherwise stated in the *EOC*
- Items and services that are not health care items and services, unless otherwise stated in the *EOC*
- Items and services to correct refractive defects of the eye (such as eye surgery or contact lenses to reshape the eye)
- Massage Therapy, unless otherwise stated in the *EOC*
- Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food, unless otherwise stated in the *EOC*
- Physical examinations related to employment, insurance, licensing, court orders, parole, or probation, unless a Plan Physician determines that the Services are Medically Necessary
- Routine foot care Services that are not Medically Necessary

- Services not approved by the federal Food and Drug Administration (FDA) that by law require FDA approval in order to be sold in the U.S., except for certain experimental or investigational Services, and as required by law for certain clinical trials
- Services performed by unlicensed people, except for behavior health treatment covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the *EOC*
- Services related to conception, pregnancy, or delivery in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate
- Services related to a noncovered Service, except for Services we would otherwise cover to treat complications of the noncovered Service
- Travel and lodging expenses, unless otherwise stated in the *EOC*
- Treatment of hair loss or growth

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes. Under these circumstances, if you have an Emergency Medical Condition, call **911** or go to the nearest hospital as described under "Emergency Services " in the "How to obtain care" section and we will provide coverage as described in that section.

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

Reductions

If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered Services, you must reimburse us to the maximum extent allowed under California Civil Code Section 3040. Note: This "Reductions" section does not affect your obligation to pay your Cost Share for these Services. Alternatively, we may file a subrogation claim on our own behalf against the third party. In addition to these third party liability claims by Kaiser Permanente, the contracts between Kaiser Permanente and some providers may allow these providers to recover all or a portion of the difference between the fees paid by Kaiser Permanente and the fees the provider charges to the general public for the Services you received.

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

To become a Member

We look forward to welcoming you as a Kaiser Permanente Member.

If you are eligible to enroll, simply return a completed enrollment application to your group.

Be sure to ask your group for your group (purchaser) number and the date when your coverage becomes effective. You can begin using our Services on your effective date of coverage. Again, if you have any questions about Kaiser Permanente, please call our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**) or you can refer to the *EOC* for details about eligibility requirements.

Persons barred from enrolling

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

Miscellaneous Notices

Completion of Services from Non-Plan Providers

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

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

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

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends
- Serious Chronic Conditions. We may cover these Services until the earlier of (1) 12 months from your membership effective date if you are a new Member; (2) 12 months from the termination date of the terminated provider; or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non-Plan Provider and consistent

with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:

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

- ▸ Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- ▸ Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- ▸ Care for children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the child's membership effective date 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 membership effective date if you are a new Member or within 180 days of the termination date of the terminated provider

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

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

Your Cost Share for completion of Services is the Cost Share required for Services provided by a Plan Provider as described in the *EOC*. **For more information about this provision or to request the Services or a copy of our "Completion of Covered Services" policy, please call our Member Service Contact Center.**

Drug formulary

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

Drug formulary guidelines allow you to obtain nonformulary prescription drugs (those not listed on our drug formulary for your condition) if they would otherwise be covered and a Plan Physician determines that they are Medically Necessary. If you disagree with your Plan Physician's determination that a nonformulary prescription drug is not Medically Necessary, you may file a grievance as described in the *EOC*. Also, our formulary guidelines may require you to participate in a Medical Group–approved behavioral intervention program for specific conditions, and you may be required to pay for the program.

Please refer to *Your Benefits (Disclosure Form Part One)* to learn if you have coverage for outpatient prescription drugs.

Privacy practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information. Your protected health information is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You may generally see

and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information. You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means.

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

This is only a brief summary of some of our key privacy practices. OUR *NOTICE OF PRIVACY PRACTICES* WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY PRACTICES AND YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION, IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. To request a copy, please call our Member Service Contact Center at **1-800-464-4000.** You can also find the notice at your local Plan Facility or on our website at **kp.org**.

Special note about Medicare

The information contained in this booklet is not applicable to most Medicare beneficiaries. Please check with your group to determine the correct *Disclosure Form* that applies to you if you are eligible for Medicare, and to learn whether you are eligible to enroll in Kaiser Permanente Senior Advantage.

Definitions

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable) and the Plan Out-of-Pocket Maximum. For example, the Accumulation Period may be a calendar year or contract year. The dates of your Accumulation Period are specified in *Your Benefits (Disclosure Form Part One).*

Adult Member: Members who are age 19 or older and not Pediatric Members.

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

Charges: Charges means the following:

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

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service. A summary of Copayments and Coinsurance is listed in *Your Benefits (Disclosure Form Part One).* For the complete list of Copayments and Coinsurance, please refer to the *EOC.*

Copayment: A specific dollar amount that you must pay when you receive a covered Service. Note: The dollar amount of the Copayment can be $0 (no charge). A summary of Copayments and Coinsurance is listed in *Your Benefits (Disclosure Form Part One).* For the complete list of Copayments and Coinsurance, please refer to the *EOC.*

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

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

Drug Deductible: The amount you must pay in the Accumulation Period for certain drugs, supplies, and supplements before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Please refer to the *Your Benefits (Disclosure Form*

Part One) to learn if your outpatient prescription drug coverage is 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 you reasonably believed that the absence of immediate medical attention would result in any of the following:

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

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

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

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

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

EOC: The *Evidence of Coverage* document, including any amendments, which describes the health care coverage under Health Plan's *Agreement* with your group.

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

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. This *Disclosure Form* sometimes refers to Health Plan as "we" or "us."

Health Savings Account ("HSA"): A tax-exempt trust or custodial account established under Section 223 (d) of the Internal Revenue Code exclusively for the purpose of paying qualified medical expenses of the account beneficiary. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a qualified High Deductible Health Plan and meet other tax law eligibility requirements.

Health Plan does not provide tax advice. Consult with your financial or tax advisor for tax advice or more information about your eligibility for a Health Savings Account.

High Deductible Health Plan ("HDHP"): A health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. The health care coverage summarized in this *Disclosure Form* has been designed to be HDHP compatible for use with a Health Savings Account.

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

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

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

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

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

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

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

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

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

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 Home Region's 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 Home Region's Service Area

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

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

Plan Deductible: The amount you must pay in the Accumulation Period for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Plan Deductible amounts are listed in *Your Benefits (Disclosure Form Part One)*. The Plan Deductible is for the calendar year unless a different Accumulation Period is specified in *Your Benefits (Disclosure Form Part One)*. If your coverage includes a Plan Deductible, please refer to the *EOC* for a list of the Services that are subject to the Plan Deductible.

Plan Facility: Any facility listed in the enclosed facility listing or on our website at **kp.org/facilities** for your Home Region's Service Area, except that Plan Facilities are subject to change at any time without notice. For the current locations of Plan Facilities, please call our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**).

Plan Hospital: Any hospital listed in the enclosed facility listing or on our website at **kp.org/facilities** for your Home Region's Service Area, except that Plan Hospitals are subject to change at any time without notice. For the current locations of Plan Hospitals, please call our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**).

Plan Medical Office: Any medical office listed in the enclosed facility listing or on our website at **kp.org/facilities** for your Home Region's Service Area, except that Plan Medical Offices are subject to change at any time without notice. For the current locations of Plan Medical Offices, please call our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**).

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay in the Accumulation Period for covered Services that you receive in the same Accumulation Period. Please refer to the *Your Benefits (Disclosure Form Part One)* to find your Plan Out-of-Pocket Maximum. Please refer to the *EOC* to learn which Services apply to the Plan Out-of-Pocket Maximum.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Please refer to *Your Guidebook* or the facility directory on our website at **kp.org** for a list of Plan Pharmacies in your Home Region's Service Area, except that Plan Pharmacies are subject to change at any time without notice. For the current locations of Plan Pharmacies, please call our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**).

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

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

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

Premiums: The periodic amounts that your group is responsible for paying for your membership under the *EOC* except that you are responsible for paying Premiums if you have Cal-COBRA coverage.

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

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

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

Contact Center at **1-800-464-4000** (TTY users call **711**).

Serious Emotional Disturbance of a Child Under Age 18: A condition identified as a "mental disorder" in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least 1 of the following 3 criteria:

- As a result of the mental disorder, (1) the child has substantial impairment in at least 2 of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than 6 months or are likely to continue for more than 1 year without treatment
- The child displays psychotic features, or risk of suicide or violence due to a mental disorder
- The child meets special education eligibility requirements under Section 5600.3(a)(2)(C) of the Welfare and Institutions Code

Service Area: For Members enrolled in the **Northern California Region,** the following ZIP codes below for each county are inside our Northern California Region Service Area:

- All ZIP codes in **Alameda County** are inside our Service Area: 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
- The following ZIP codes in **Amador County** are inside our Service Area: 95640, 95669
- All ZIP codes in **Contra Costa County** are inside our Service Area: 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
- The following ZIP codes in **El Dorado County** are inside our Service Area: 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in **Fresno County** are inside our Service Area: 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
- The following ZIP codes in **Kings County** are inside our Service Area: 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in **Madera County** are inside our Service Area: 93601-02, 93604, 93614, 93623, 93626, 93636-39, 93643-45, 93653, 93669, 93720
- All ZIP codes in **Marin County** are inside our Service Area: 94901, 94903-04, 94912-15, 94920, 94924-25, 94929-30, 94933, 94937-42, 94945-50, 94956-57, 94960, 94963-66, 94970-71, 94973-74, 94976-79
- The following ZIP codes in **Mariposa County** are inside our Service Area: 93601, 93623, 93653
- All ZIP codes in **Napa County** are inside our Service Area: 94503, 94508, 94515, 94558-59, 94562, 94567, 94573-74, 94576, 94581, 94599, 95476
- The following ZIP codes in **Placer County** are inside our Service Area: 95602-04, 95610, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95703, 95722, 95736, 95746-47, 95765
- All ZIP codes in **Sacramento County** are inside our Service Area: 94203-09, 94211, 94229-30, 94232, 94234-37, 94239-40, 94244, 94247-50, 94252, 94254, 94256-59, 94261-63, 94267-69, 94271, 94273-74, 94277-80, 94282-85, 94287-91, 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
- All ZIP codes in **San Francisco County** are inside our Service Area: 94102-05, 94107-12, 94114-27, 94129-34, 94137, 94139-47, 94151, 94158-61, 94163-64, 94172, 94177, 94188
- All ZIP codes in **San Joaquin County** are inside our Service Area: 94514, 95201-15, 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
- All ZIP codes in **San Mateo County** are inside our Service Area: 94002, 94005, 94010-11, 94014-21, 94025-28, 94030, 94037-38, 94044, 94060-66, 94070, 94074, 94080, 94083, 94128, 94303, 94401-04, 94497
- The following ZIP codes in **Santa Clara County** are inside our Service Area: 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
- All ZIP codes in **Santa Cruz County** are inside our Service Area: 95001, 95003, 95005-7, 95010, 95017-19, 95033, 95041, 95060-67, 95073, 95076-77
- All ZIP codes in **Solano County** are inside our Service Area: 94503, 94510,

94512, 94533-35, 94571, 94585, 94589-92, 95616, 95618, 95620, 95625, 95687-88, 95690, 95694, 95696

- The following ZIP codes in **Sonoma County** are inside our Service Area: 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
- All ZIP codes in **Stanislaus County** are inside our Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322-23, 95326, 95328-29, 95350-58, 95360-61, 95363, 95367-68, 95380-82, 95385-87, 95397
- The following ZIP codes in **Sutter County** are inside our Service Area: 95626, 95645, 95659, 95668, 95674, 95676, 95692, 95836-37
- The following ZIP codes in **Tulare County** are inside our Service Area: 93618, 93631, 93646, 93654, 93666, 93673
- The following ZIP codes in **Yolo County** are inside our Service Area: 95605, 95607, 95612, 95615-18, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99
- The following ZIP codes in **Yuba County** are inside our Service Area: 95692, 95903, 95961

For Members enrolled in the **Southern California Region**, The ZIP codes below for each county are in our Service Area:

- The following ZIP codes in **Imperial County** are inside our Service Area: 92274-75
- The following ZIP codes in **Kern County** are inside our Service Area: 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380, 93383-90, 93501-02, 93504-05, 93518-19, 93531, 93536, 93560-61, 93581
- The following ZIP codes in **Los Angeles County** are inside our Service Area: 90001-84, 90086-91, 90093-96, 90099, 90189, 90201-02, 90209-13, 90220-24, 90230-33, 90239-42, 90245, 90247-51, 90254-55, 90260-67, 90270, 90272, 90274-75, 90277-78, 90280, 90290-96, 90301-12, 90401-11, 90501-10, 90601-10, 90623, 90630-31, 90637-40, 90650-52, 90660-62, 90670-71, 90701-03, 90706-07, 90710-17, 90723, 90731-34, 90744-49, 90755, 90801-10, 90813-15, 90822, 90831-35, 90840, 90842, 90844, 90846-48, 90853, 90895, 90899, 91001, 91003, 91006-12, 91016-17, 91020-21, 91023-25, 91030-31, 91040-43, 91046, 91066, 91077, 91101-10, 91114-18, 91121, 91123-26, 91129, 91182, 91184-85, 91188-89, 91199, 91201-10, 91214, 91221-22, 91224-26, 91301-11, 91313, 91316, 91321-22, 91324-31, 91333-35, 91337, 91340-46, 91350-57, 91361-62, 91364-65, 91367, 91371-72, 91376, 91380-87, 91390, 91392-96, 91401-13, 91416, 91423, 91426, 91436, 91470, 91482, 91495-96, 91499, 91501-08, 91510, 91521-23, 91526, 91601-12, 91614-18, 91702, 91706, 91711, 91714-16, 91722-24, 91731-35, 91740-41, 91744-50, 91754-56, 91759, 91765-73, 91775-76, 91778, 91780, 91788-93, 91801-04, 91896, 91899, 93243, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93560, 93563, 93584, 93586, 93590-91, 93599
- All ZIP codes in **Orange County** are inside our Service Area: 90620-24, 90630-33, 90638, 90680, 90720-21, 90740, 90742-43, 92602-07, 92609-10, 92612, 92614-20, 92623-30, 92637, 92646-63, 92672-79, 92683-85, 92688, 92690-94, 92697-98, 92701-08, 92711-12, 92728, 92735, 92780-82, 92799, 92801-09, 92811-12, 92814-17, 92821-23, 92825, 92831-38, 92840-46, 92850, 92856-57, 92859, 92861-71, 92885-87, 92899
- The following ZIP codes in **Riverside County** are inside our Service Area: 91752, 92028, 92201-03, 92210-11, 92220, 92223, 92230, 92234-36, 92240-41, 92247-48, 92253-55, 92258, 92260-64, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501-09, 92513-14, 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
- The following ZIP codes in **San Bernardino County** are inside our Service Area: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91766, 91784-86, 91792, 92252, 92256, 92268, 92277-78, 92284-86, 92305, 92307-08, 92313-18, 92321-22, 92324-25, 92329, 92331, 92333-37, 92339-41, 92344-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-95, 92397, 92399, 92401-08, 92410-11, 92413, 92415, 92418, 92423, 92427, 92880
- The following ZIP codes in **San Diego County** are inside our Service Area: 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-46, 91950-51, 91962-63, 91976-80, 91987, 92003, 92007-11, 92013-14, 92018-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-61, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-86, 92088, 92091-93, 92096, 92101-24, 92126-32, 92134-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-61, 92163, 92165-79, 92182, 92186-87, 92190-93, 92195-99
- The following ZIP codes in **Tulare County** are inside our Service Area: 93238, 93261
- The following ZIP codes in **Ventura County** are inside our Service Area: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07, 93009-12, 93015-16, 93020-22, 93030-36, 93040-44, 93060-66, 93094, 93099, 93252

For each ZIP code listed for a county, our Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another

county is not inside our Service Area unless that other county is listed above and that ZIP code is also listed for that other county.

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

Services: Health care services or items ("health care" includes both physical health care and mental health care), behavioral health treatment covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the *EOC*, and services to treat Severe Mental Illness or Serious Emotional Disturbance of a Child Under Age 18.

Severe Mental Illness: The following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa.

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

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber.

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

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

Notes

Notes

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