2024 National Enrollment Guide

Care for all that is you

kp.org/allthatisyou

KAISER PERMANENTE®

Experience health care designed with you in mind

Care for …

Routine checkups, complex treatments, and late-night questions

Building strength, reducing stress, and raising a family

New goals, old habits, and ongoing mental wellness

No matter what your priority is, ours is providing excellent care – for the you who's feeling great, the you who needs support, and every you in between.

Disclosure Form Part One

100600 UNITE HERE HEALTH DHMO+
Home Region: Southern California
1/1/24 through 12/31/24

Principal benefits for Kaiser Permanente Deductible HMO Plan

Accumulation Period

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

Out-of-Pocket Maximums and Deductibles

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

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

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Out-of-Pocket Maximum	$3,000	$3,000	$6,000
Plan Deductible	$1,000	$1,000	$2,000
Drug Deductible	None	None	None

Plan Provider Office Visits	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$20 per visit (Plan Deductible doesn't apply)
Most Physician Specialist Visits	$20 per visit (Plan Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Plan Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Plan Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Plan Deductible doesn't apply)
Routine eye exams with a Plan Optometrist	No charge (Plan Deductible doesn't apply)
Urgent care consultations, evaluations, and treatment	$20 per visit (Plan Deductible doesn't apply)
Most physical, occupational, and speech therapy	$20 per visit (Plan Deductible doesn't apply)

Telehealth Visits	**You Pay**
Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by interactive video	No charge (Plan Deductible doesn't apply)
Primary Care Visits and Non-Physician Specialist Visits by telephone	No charge (Plan Deductible doesn't apply)
Physician Specialist Visits by telephone	No charge (Plan Deductible doesn't apply)

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Plan Deductible
Most immunizations (including the vaccine)	No charge (Plan Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter (Plan Deductible doesn't apply)
Preventive X-rays, screenings, and laboratory tests as described in the *EOC*	No charge (Plan Deductible doesn't apply)
MRI, most CT, and PET scans	20% Coinsurance up to a maximum of $50 per procedure (Plan Deductible doesn't apply)

Hospital Inpatient Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance after Plan Deductible

Emergency Services	**You Pay**
Emergency department visits	20% Coinsurance after Plan Deductible

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the emergency department Cost Share (see "Hospital Inpatient Services" for inpatient Cost Share)

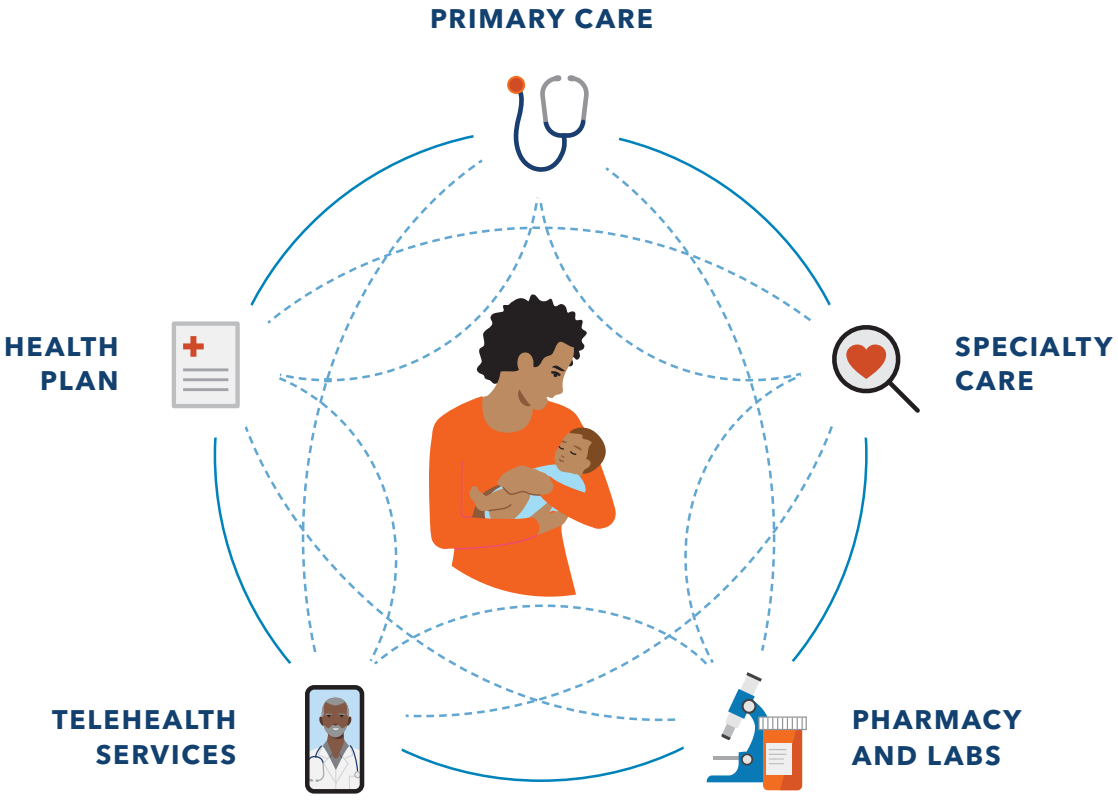
Ambulance Services	**You Pay**
Ambulance Services	$150 per trip (Plan Deductible doesn't apply)

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items (Tier 1) at a Plan Pharmacy	$10 for up to a 30-day supply (Plan Deductible doesn't apply)
Most generic (Tier 1) refills through our mail-order service	$20 for up to a 100-day supply (Plan Deductible doesn't apply)

(continues)

Prescription Drug Coverage	You Pay
Most brand-name items (Tier 2) at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Most brand-name (Tier 2) refills through our mail-order service	$60 for up to a 100-day supply (Plan Deductible doesn't apply)
Most specialty items (Tier 4) at a Plan Pharmacy	$30 for up to a 30-day supply (Plan Deductible doesn't apply)
Durable Medical Equipment (DME)	**You Pay**
DME items as described in the *EOC*	20% Coinsurance (Plan Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	20% Coinsurance after Plan Deductible
Individual outpatient mental health evaluation and treatment	$20 per visit (Plan Deductible doesn't apply)
Group outpatient mental health treatment	$10 per visit (Plan Deductible doesn't apply)
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	20% Coinsurance after Plan Deductible
Individual outpatient substance use disorder evaluation and treatment	$20 per visit (Plan Deductible doesn't apply)
Group outpatient substance use disorder treatment	$5 per visit (Plan Deductible doesn't apply)
Home Health Services	**You Pay**
Home health care (up to 100 visits per Accumulation Period)	No charge (Plan Deductible doesn't apply)
Other	**You Pay**
Hearing aids every 36 months	Amount in excess of $3,000 Allowance per aid (Allowance not subject to Plan Deductible)
Skilled nursing facility care (up to 100 days per benefit period)	20% Coinsurance (Plan Deductible doesn't apply)
Prosthetic and orthotic devices as described in the *EOC*	No charge (Plan Deductible doesn't apply)
Diagnosis and treatment of infertility and artificial insemination (such as outpatient procedures or laboratory tests) as described in the *EOC*	50% Coinsurance (Plan Deductible doesn't apply)
Assisted reproductive technology ("ART") Services	Not covered
Hospice care	No charge (Plan Deductible doesn't apply)

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



Built to make your life easier

Combined care and coverage means your Kaiser Permanente doctors, hospitals, and health plan benefits are all connected and committed to providing you with exceptional care tailored to your needs.

It's easier access to top specialists and the latest treatments.

It's predictable costs and less paperwork.

It's the right care, when you need it.

Find out how we can help you stay healthy and keep doing what you love.
kp.org/allthatisyou

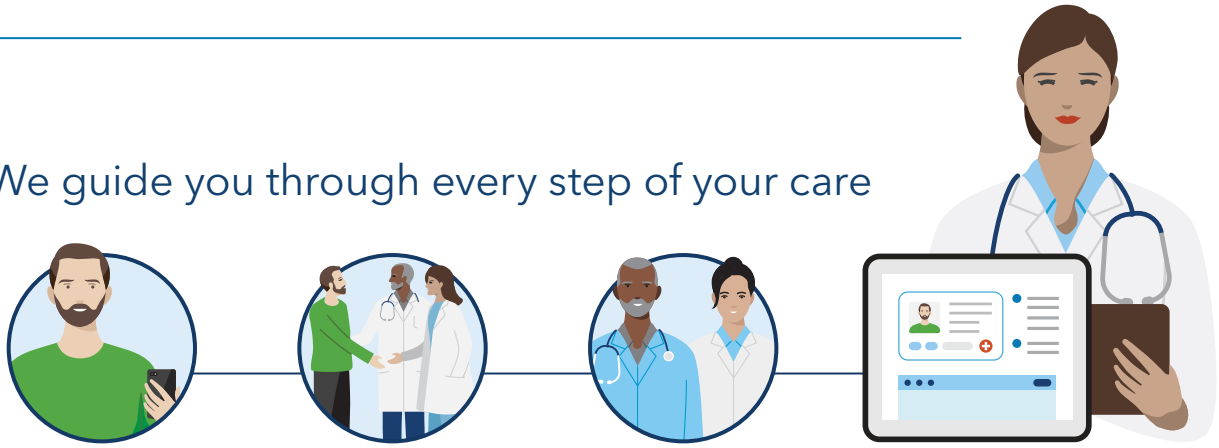
Care that's **personalized**

For the you who deserves to be understood

Kaiser Permanente doctors have one priority: your health. Your electronic health record connects your care team with your health history, so your doctor can plan the right care for your needs. They learn your lifestyle, risks, and goals to understand what matters most to you and be your best health advocate.

Explore care that fits your life.
kp.org/connectedtocare

We guide you through every step of your care



Your health history lives on your electronic health record.

Your doctor guides you through appointments and referrals.

Your health record is available to you and your care team 24/7.

Your care team lets you know when to schedule checkups and tests.

Care that's **convenient**

For the you with a busy schedule

Visit kp.org or use our app to make a routine same-day or next-day appointment in person, or talk to a clinician 24/7 by phone or video.[1] No matter how you connect, you'll always talk with a medical professional who can see your health history and pick up where you left off.

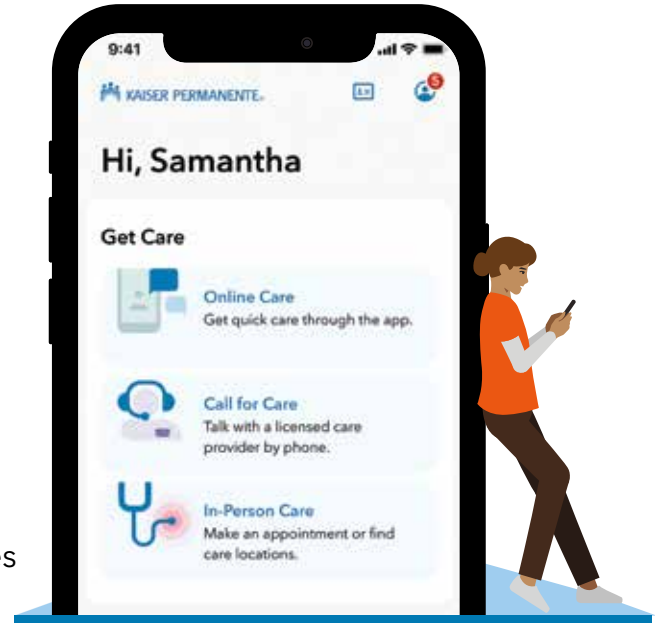
Do more in one visit

Many of our facilities have pharmacies and labs in the same building, so you can see your doctor, get your tests, and pick up your prescriptions all in one stop.

Your health at your fingertips

- Get 24/7 virtual care
- Email your care team
- View most lab results and doctor's notes
- Refill most prescriptions
- Check in for appointments
- Pay bills and view statements

See how the Kaiser Permanente app puts you in control.
kp.org/mobile



FAST COMPANY | THE WEBBY AWARDS

Our mobile app won Fast Company's 2022 Design Company of the Year and the 2022 People's Voice Webby award for Health and Fitness Apps.

You're covered while traveling

If you're planning to travel, we can help you manage your vaccinations, refill prescriptions, and more. And once you're on the go, you're covered for urgent and emergency care anywhere in the world – even at non-Kaiser Permanente facilities.

Care that's **world class**

For the you who expects the best

No matter your needs – mental health, maternity, cancer care, heart health, and beyond – you have access to expert doctors, cutting-edge technology, and the latest evidence-based care.

Learn how our doctors and specialists work for you.
kp.org/specialtycare

We're a national leader in screening rates and research, and we're among the top-rated health plans in every state we serve.[2,3,4]

Kaiser Permanente members are:

33%
more likely to survive heart disease[5]

52%
more likely to survive colorectal cancer[6]

20%
less likely to experience premature death due to cancer[7]

All 39 of our hospitals have been recognized by U.S. News & World Report as high performing in one or more types of care.

Care that's **all encompassing**

For the you who wants to explore all your health options

Kaiser Permanente members can get help with depression, anxiety, addiction, and mental or emotional health – without a referral. You also have access to self-care apps to help your overall mental wellness.[8,9]

Calm

The number one app for sleep and meditation

Ginger

Text one-on-one with an emotional support coach anytime, anywhere[10]

myStrength

Build a personalized plan to strengthen your emotional health

Find out more about mental health care.
kp.org/mentalhealth

Resources for everyday wellness

Take advantage of classes, services, and programs to help you achieve your health and fitness goals.[11]

- Acupuncture, massage therapy, and chiropractic care
- Reduced rates on gym memberships
- Healthy lifestyle programs
- Wellness coaching
- Online fitness with the ClassPass app

Care that's **dependable**

For the you who wants a doctor you trust

Your health is a lifelong journey, and we want you to have the right doctor to go the distance. We hire doctors and staff who speak more than one language and deliver care that's sensitive to your culture, ethnicity, and lifestyle. And you can choose or change your doctor anytime.

From finding the right doctor to transitioning care, we'll help you with every step.
kp.org/newmember

> Dr. Weniger was relatable, kind, and thorough. By the end of my visit, I knew I made the right choice in Kaiser Permanente.
>
> **– Aimee,** new member

1090410572 June 2023

Hospital Services Deductible HMO Plan

Understand your costs

With this Kaiser Permanente deductible health plan, you get a wide range of care and support to help you stay healthy, including no-cost preventive care[1] and doctor's visits, labs, screenings, and prescriptions at a copay or coinsurance – even before you meet your deductible.

Features include:

- $0 Most preventive care services – like routine physical exams, mammograms, and cholesterol screenings – are covered at no cost.[1]
- Pay predictable copays or coinsurance for doctor visits, labs, screenings, and prescriptions – even before you meet your deductible.
- You don't need a referral for certain specialties, like optometry and obstetrics-gynecology.
- Our personalized online estimate tools help you better understand what you'll pay for medical services and prescriptions based on your health plan.
- Your out-of-pocket maximum helps limit how much you could spend for care each year.

Definitions

Coinsurance – A percentage of the charges that you pay for covered services. Example: 20% coinsurance for a $200 outpatient procedure is $40.

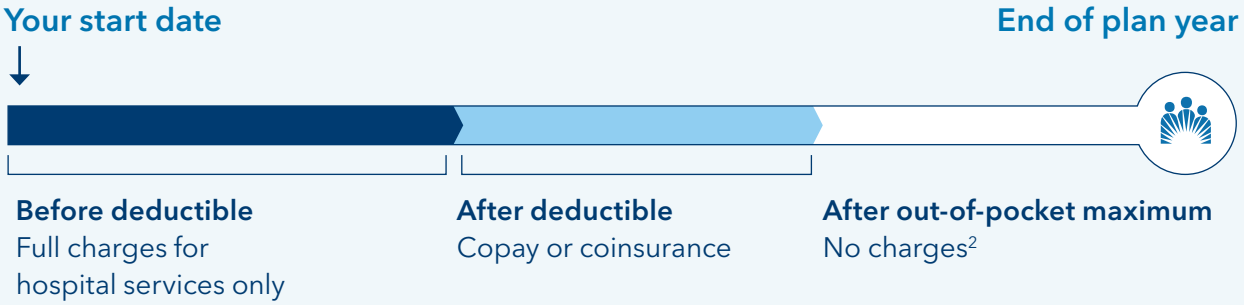
Copay – A set amount you pay for covered services. Example: $20 for an office visit and $10 for generic prescription drugs.

Deductible – The amount you pay for certain services before Kaiser Permanente starts to pay. Example: A $500 deductible means you'll pay the full costs up to $500 before you start paying copays or coinsurance.

Out-of-pocket maximum – The maximum amount you'll pay for covered services each year.[2]

What you can expect

We make it simple for you to understand what you'll pay for care.
Visit **kp.org/deductibleplans** for resources on understanding your plan costs.



How much you pay for care

- When you get care without staying in the hospital, you'll pay a copay or coinsurance for most services. Kaiser Permanente covers the rest.
- For hospital services, you'll pay the full cost until you reach a set amount known as your deductible. Then you'll start paying less – a copay or coinsurance – for the rest of the year.
- You also have an out-of-pocket maximum. If you reach your maximum, you won't pay for most covered services for the rest of the year.[2]
- You'll get most preventive care at no cost or at a copay, even before you reach your deductible.[1] Learn more at **kp.org/prevention**.

How much your family pays for care

- If your family is covered under your plan, you also have a family deductible for hospital services and an out-of-pocket maximum.
  - If you reach your family deductible, everyone in your family will start paying a copay or coinsurance for covered hospital services instead of full cost – even if they haven't met their individual deductibles.
  - If you reach the family out-of-pocket maximum, no one in your family will have to pay for most covered services for the rest of the year – even if they haven't met their individual out-of-pocket maximums.[2]

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Paying for additional services

- When you check in for a visit, you'll make a payment for the services you're scheduled to receive. Your payment may only cover part of what you owe, especially if you get unscheduled services during your visit. In that case, you'll get a bill later for the difference.
- You can get care online, over the phone, and by video for $0. This includes phone appointments,[3] video visits,[3] 24/7 advice, e-visits, and email. Learn more at **kp.org/getcare**.

Predictable prescription costs

- Generic, brand-name, and specialty drugs are covered at a copay or coinsurance when you fill your prescriptions through a Kaiser Permanente pharmacy.
- Many of our facilities have pharmacies, but you can also fill prescriptions online, in the Kaiser Permanente app, over the phone, or by mail.

Plan ahead by getting cost estimates before getting care

- Once you're a member, you can register on kp.org, where you can get a personalized estimate for services you're scheduled to receive. The tool also shows how close you are to reaching your deductible and out-of-pocket maximum.
- You can also get estimates for prescription drug costs with our pharmacy estimates tool.

For more details about your plan, including your specific deductible, copay, coinsurance, out-of-pocket maximum, and prescription amounts, see the *Disclosure Form Part One* and *Disclosure Form Part Two* or ask your benefits manager for your *Evidence of Coverage*.

1. Depending on your plan. **2.** In some cases, you'll still pay a copay or coinsurance after reaching your out-of-pocket maximum.
3. When appropriate and available.

Your costs during preventive care visits

Preventive care visits can help you stay healthy. Depending on your plan, most of these visits are covered at no cost. But if you have symptoms of a health condition, you may need diagnostic or treatment services. If that happens, you may get a bill for those additional services. Learn more at **kp.org/prevention**.

Preventive care

The purpose of a preventive care visit is to help keep you healthy and uncover possible health problems early.

Examples

- Blood pressure screening for all adults
- Colorectal cancer screening for adults over 50
- Type 2 diabetes screening for adults with high blood pressure
- Immunizations for children from birth to 18 years

What you'll pay

For most members, preventive care visits are covered at no cost.

Learn more

For a full list of preventive care services, visit **kp.org/prevention**.

Diagnostic or treatment services

Any care or service that's used to diagnose or treat a health problem is not considered preventive. These services are given in response to symptoms of a health condition.

Examples

- Most prescription drugs, when used to treat or manage a condition you already have
- Lab tests or X-rays
- Procedures, like removing a mole or getting stitches

What you'll pay

Diagnostic or treatment services may result in a bill – which may include a deductible, copay, or coinsurance.

Learn more

For questions about a medical bill, visit **kp.org/mybenefits** or call **1-800-464-4000,** 24/7 (closed holidays) or **711** (TTY). We also offer payment plans and financial assistance for members who qualify.

Visit **kp.org/deductibleplans**

KAISER PERMANENTE®

695775562 September 2021

Colorado state law requires that an access plan be available that describes Kaiser Foundation Health Plan of Colorado's network of provider services. To obtain a copy, please call Member Services or visit kp.org.

Kaiser Permanente health plans around the country: Kaiser Foundation Health Plan, Inc., in Northern and Southern California and Hawaii • Kaiser Foundation Health Plan of Colorado • Kaiser Foundation Health Plan of Georgia, Inc., Nine Piedmont Center, 3495 Piedmont Road NE, Atlanta, GA 30305, 404-364-7000 • Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., in Maryland, Virginia, and Washington, D.C., 2101 E. Jefferson St., Rockville, MD 20852 • Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232 • Kaiser Foundation Health Plan of Washington or Kaiser Foundation Health Plan of Washington Options, Inc., 1300 SW 27th St., Renton, WA 98057

Disclosure Form Part Two

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

Overview of your coverage

Kaiser Permanente Traditional HMO Plan
Kaiser Permanente Deductible HMO Plan
Kaiser Permanente HSA-Qualified High Deductible Health Plan (HDHP) HMO Plan

Introduction

This *Disclosure Form Part Two* provides an overview of some of the important features of your Kaiser Permanente membership. Please refer to *Disclosure Form Part One* for a summary of the most frequently asked-about benefits.

These documents are only a summary of your Health Plan coverage. For details about the terms and conditions of coverage, refer to the *Evidence of Coverage ("EOC").* You have the right to review the *EOC* before enrolling. To obtain a copy, please contact your group.

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY OBTAIN HEALTH CARE. If you have special health care needs, carefully read the sections that apply to you.

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Service Areas in California (the Northern California or Southern California Region), which we call your "Home Region." 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, covered Services received outside of your Home Region Service Area, 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 Member Services 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.

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 Kaiser Permanente Member Services at 1-800-464-4000 (TTY users call 711), to ensure that you can obtain the health care services that you need."**

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 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
- Covered Services received outside of your Home Region Service Area

For Plan Facility locations, refer to the facility listing on our website at **kp.org/facilities**, or call Member Services 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 emergency department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non-Plan Providers anywhere in the world.

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

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider, you are not responsible for any amounts beyond your Cost Share for covered Emergency Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement.

Post-Stabilization Care

We cover Post-Stabilization Care from a Non–Plan Provider in the following circumstances (refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section of your *EOC* for details):

- When you receive Post-Stabilization Care from a Non-Plan Provider inside of California, or from a Cigna PPO Network facility outside of a Kaiser Permanente State, we cover the Services only if prior authorization for the care is obtained or if otherwise required by applicable law (prior authorization means that the Services must be approved in advance).
- Post-Stabilization Care from all other providers outside of California if it qualifies as Emergency Services under federal law (your treating physician has determined that you are not able to travel to a Plan Provider taking into account your medical condition or you or your authorized representative are not in a condition to be able to provide consent in accord with state informed consent law).

You are responsible for the full cost of Services from a Non-Plan Provider after your condition has been Stabilized in the following circumstances:

- If you receive Post-Stabilization Care that has not been authorized from a Non–Plan Provider inside California or a Cigna PPO Network facility outside of a Kaiser Permanente State
- If you receive Post-Stabilization Care that doesn't qualify as Emergency Services from any other provider outside of California that has not been authorized (in such circumstances, the Non-Plan Provider may provide notice and seek your consent to provide the Services, but these Service are not covered unless we have authorized them)

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

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 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 Member Services if we ever inadvertently issue you more than one medical record number or if you need to replace your 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 Member Services at **1-800-464-4000** (TTY users call **711)**.

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available at Plan Hospital emergency departments listed in *Your Guidebook* (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 (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 office (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 Member Services at **1-800-464-4000** (TTY users call **711**), 24 hours a day, seven 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 Member Services 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 Autism Spectrum Disorder" 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 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 Member Services to request a printed copy. 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, refer to the *EOC* or call Member Services 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, 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 appointment: within 48 hours
- Routine (non-urgent) primary care appointment (including adult/internal medicine, pediatrics, and family medicine): within 10 business days
- Routine (non-urgent) specialty care appointment with a physician: within 15 business days
- Routine (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician: within 10 business days

- Follow-up (non-urgent) mental health care or substance use disorder treatment appointment with a practitioner other than a physician, for those undergoing a course of treatment for an ongoing mental health or substance use disorder condition: within 10 business days

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

Timely access to telephone assistance

- DMHC developed the following standards for answering telephone questions:
- For telephone advice about whether you need to get care and where to get care: within 30 minutes, 24 hours a day, seven days a week.
- For general questions: within 10 minutes during normal business hours.

Interpreter Services

If you need interpreter services when you call us or when you get covered 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 Member Services.

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 Member Services 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

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 Member Services.

- 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. 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, seven 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)*. Refer to the *EOC* for the complete list of Copayments and Coinsurance.

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

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. 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)*. Note: The Plan Deductible amount for a High Deductible Health Plan is subject to increase if the U.S. Department of the Treasury changes the required minimum deductible.

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 subject to the Plan Deductible you must pay Charges for those Services until you meet the deductible. Refer to the *EOC* for more information about which Services are subject to the Plan Deductible and an explanation of how the deductible works.

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. 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. Refer to *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)*. Refer to the *EOC* to learn which Services apply to the Plan Out-of-Pocket Maximum.

Accrual toward deductibles and out-of-pocket maximums

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

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

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.

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 Member Services toll free at **1-800-464-4000** (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 Member Services 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.

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)

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. 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 Member Services. 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, seven days a week (except closed holidays)
Visit	Member Services office at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for addresses)
Write	Member Services office 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 Services representatives can help you with unresolved issues at our Plan Facilities or by phone at **1-800-464-4000** (TTY users call **711**). 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 **1-888-466-2219** 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. 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. These exclusions or limitations do not apply to Services that are Medically Necessary

to treat mental health conditions or substance use disorders that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that are listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

- 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 (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, formulas, food, and weight loss aids, 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 Autism Spectrum Disorder" 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 emergency department as described under "Emergency Services " in the "How to obtain care" section and we will provide coverage as described in that section.

Reductions

If you obtain a judgment or settlement from or on behalf of another party who allegedly caused an injury or illness for which you received covered 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 other party. In addition to these other 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.

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 Member Services 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
- Mental health conditions in pregnant Members that occur, or can impact the Member, during pregnancy or during the postpartum period including, but not limited to, postpartum depression. We may cover completion of these Services for up to 12 months from the mental health diagnosis or from the end of pregnancy, whichever occurs later
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- 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 Service Area (the requirement that the provider agree to providing Services inside your Home Region 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** Member Services**.**

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 Service Area. Our Pharmacy and Therapeutics Committee, which is primarily comprised of Plan Physicians and pharmacists, selects drugs for the drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature. The drug formulary is updated monthly based on new information or new 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 Member Services. Note: The presence of a drug on the drug formulary does not necessarily mean that it will be prescribed for a particular medical condition.

Drug formulary guidelines allow you to obtain a nonformulary prescription drug (those not listed on our drug formulary for your condition) if it would otherwise be covered by your plan and it is Medically Necessary. If you disagree with a Plan determination that a nonformulary prescription drug is not covered, you may file a grievance as described in the *EOC*.

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. You may request confidential communication by completing a confidential communication request form, which is available on kp.org under “Request for confidential communications forms.” Your request for confidential communication will be valid until you submit a revocation or a new request for confidential communication. If you have questions, please call Member Services.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give protected health information to others, such as government agencies 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 Member Services 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 pre-enrollment disclosure 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)*.

Allowance: A specified amount that you can use toward the purchase price of an item. If the price of the items you select exceeds the Allowance, you will pay the amount in excess of the Allowance (and that payment will not apply toward 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 air ambulance Services received from Non-Plan Providers when you have an Emergency Medical Condition, the amount required to be paid by Health Plan pursuant to federal law
- For other Emergency Services received from Non-Plan Providers (including Post-Stabilization Care that constitutes Emergency Services under federal law), the amount required to be paid by Health Plan pursuant to state law, when it is applicable, or federal law
- For all other Services received from Non-Plan Providers (including Post-Stabilization Services that are not Emergency Services under federal law), the amount (1) required to be paid pursuant to state law, when it is applicable, or federal law, or (2) in the event that neither state or federal law prohibiting balance billing apply, then the amount agreed to by the Non-Plan Provider and Health Plan or, absent such an agreement, the usual, customary and reasonable rate for those services as determined by Health Plan based on objective criteria
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts your Cost Share from its payment, the amount Kaiser Permanente would have paid if it did not subtract 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, 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, 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 under the *EOC* 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. Refer to *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 person, the health of the pregnant person or 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 themself 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 or an independent freestanding emergency department, 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 facility, 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)
- Post-Stabilization Care furnished by a Non-Plan Provider is covered as Emergency Services when federal law applies, as described under “Post-Stabilization Care” in the “Emergency Services” section of the *EOC*

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 their 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 an 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.

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

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: For Services related to mental health or substance use disorder treatment, a Service is Medically Necessary if it is addressing your specific needs, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of mental health and substance use disorder care
- Clinically appropriate in terms of type, frequency, extent, site, and duration
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider

For all other Services, 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).

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 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 Service Area

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

Plan Deductible: The amount you must pay under the *EOC* 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, 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 Service Area. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The information in this online directory is updated periodically. The availability Plan Facilities may change. If you have questions, please call Member Services 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 Service Area. In the directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The information in this online directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call Member Services 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 Service Area. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The information in this online directory is updated periodically. The availability of Plan Medical Offices may change. If you have questions, please call Member Services 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. Refer to the *Your Benefits (Disclosure Form Part One)* to find your Plan Out-of-Pocket Maximum. Refer to the *EOC* to learn which Services apply to the Plan Out-of-Pocket Maximum.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the directory on our website at **kp.org/facilities** for your Home Region Service Area for locations of Plan Pharmacies in your area. The information in this online directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call Member Services 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 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 Service Area.

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

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.

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 Member Services at **1-800-464-4000** (TTY users call **711**).

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, 95836-7
- 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, 90134, 90189, 90201-02, 90209-13, 90220-24, 90230-32, 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, 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, 92191-93, 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 Service Area at any time by giving written notice to your group. ZIP codes are subject to change by the U.S. Postal Service.

Services: Health care services or items ("health care" includes both physical health care and mental health care) and behavioral health treatment covered under "Behavioral Health Treatment for Autism Spectrum Disorder" in the *EOC*.

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 person who is having contractions, when there is inadequate time to safely transfer them to another hospital before delivery (or the transfer may pose a threat to the health or safety of the pregnant person or unborn child), "Stabilize" means to deliver (including the placenta).

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

Surrogacy Arrangement: An arrangement in which an individual agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the individual receives payment for being a surrogate. For the purposes of the *EOC*, "Surrogacy Arrangements" includes all types of surrogacy arrangements, including traditional surrogacy arrangements and gestational surrogacy arrangements.

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.

Important Notices

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. You can also request auxiliary aids and devices at our facilities. 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. يمكنك أيضاً طلب مساعدات إضافية وأجهزة في مرافقنا. ما عليك سوى الاتصال بنا على الرقم **1-800-464-4000** على مدار الساعة كافة أيام الأسبوع (مغلق أيام العطلات). لمستخدمي خدمة الهاتف النصي يرجى 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: Դուք նաև կարող եք խնդրել օժանդակ օգնություններ և սարքեր մեր հաստատություններում: 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。您還可以在我們的場所內申請使用輔助工具和設備。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 مدارک به زبان شما و یا به صورتهای دیگر درخواست کنید. شما همچنین می توانید کمکهای جانبی و وسایل کمکی برای محل اقامت خود 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 ناشنوا (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। आप हमारे सुविधा-स्थलों में सहायक साधनों और उपकरणों के लिए भी 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: Muaj kec 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. Koj kuj thov tau lwm yam kev pab thiab khoom siv hauv peb tej tsev hauj lwm. 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。補助サービスや当施設の機器についてもご相談いただけます。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 គឺឥតគិតថ្លៃថ្លៃដល់អ្នកឡើយ 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែឯកសារដែលបានបកប្រែទៅជាភាសាខ្មែរ ឬជាទំរង់ជំនួសផ្សេងៗទៀត។ អ្នកក៏អាចស្នើសុំឧបករណ៍និងបរិក្ខារជំនួយទំនាក់ទំនងសម្រាប់អ្នកពិការនៅទីតាំងរបស់យើងផងដែរ។ គ្រាន់តែទូរស័ព្ទមកយើង តាមលេខ **1-800-464-4000** បាន 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្តាហ៍ (បិទថ្ងៃបុណ្យ)។ អ្នកប្រើ TTY ហៅលេខ 711។

Korean: 요일 및 시간에 관계없이 언어지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스,귀하의 언어로 번역된 자료 또는 대체 형식의 자료를 요청할 수 있습니다. 또한 저희 시설에서 보조기구 및 기기를 요청하실 수 있습니다. 요일 및 시간에 관계없이 **1-800-464-4000** 번으로 전화하십시오 (공휴일휴무). TTY 사용자번호 **711**.

Laotian: ການຊ່ວຍເຫຼືອດ້ານພາສາມີໃຫ້ໂດຍບໍ່ເສັງຄ່າ ແກ່ທ່ານ, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ. ທ່ານ ສາມາດຮ້ອງຂໍຮັບບໍລິການນາຍພາສາ, ໃຫ້ແປເອກະ ສານເປັນພາສາຂອງທ່ານ, ຫຼື ໃນຮູບແບບອື່ນ. ທ່ານສາມາດຂໍອຸປະກອນຊ່ວຍເສີມ ແລະ ອຸປະກອນ ຕ່າງໆໃນສະຖານບໍລິການຂອງພວກເຮົາໄດ້.ພຽງແຕ່ໂທ ຫາພວກເຮົາທີ່ **1-800-464-4000**, ຕະຫຼອດ 24 ຊົ່ວໂມງ, 7 ວັນຕໍ່ອາທິດ (ປິດວັນພັກຕ່າງໆ). ຜູ້ໃຊ້ສາຍ TTY ໂທ **711**.

Mien: Mbenc nzoih liouh wang-henh tengx nzie faan waac bun muangx maiv zuqc cuotv zinh nyaanh meih, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm liv baaiz mbenc maaih 7 hnoi. Meih se haih tov heuc tengx lorx faan waac mienh tengx faan waac bun muangx, dorh nyungc horngh jaa-sic mingh faan benx meih nyei waac, a'fai liouh ginv longc benx haaix hoc sou-guv daan yaac duqv. Meih corc haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Kungx douc waac mingh lorx taux yie mbuo yiem njiec naaiv **1-800-464-4000**, yietc hnoi mbenc maaih 24 norm ziangh hoc, yietc norm liv baaiz mbenc maaih 7 hnoi. (hnoi-gec se guon gorn zangc oc). TTY nyei mienh nor douc waac lorx **711**.

Navajo: Doo bik'é asiníłáágóó saad bee ata' hane' bee áká e'elyeed nich'į' ąą'át'é, t'áá áłahjį' jį́į́go dóó tł'ée'go áádóó tsosts'ijí ąą'át'é. Ata' hane' yídiikił, naaltsoos t'áá Diné bizaad bee bik'i' ashchíigo, éí doodago hane' bee didiits'iiłígíí yídiikił. Hane' bee bik'i' di'diitíłígíí dóó bee hane' didiits'iiłígíí bina'idiłkidgo yídiikił. Kojį hodiilnih **1-800-464-4000**, t'áá áłahjį', jį́į́go dóó tł'ée'go áádóó tsosts'ijí ąą'át'é. (Dahodilzingóne' doo nida'anish dago éí da'deelkaal). TTY chodayooł'ínígíí kojį dahalne' **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। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸੁਵਿਧਾਵਾਂ ਵਿੱਚ ਵੀ ਸਹਾਇਕ ਸਾਧਨਾਂ ਅਤੇ ਉਪਕਰਣਾਂ ਲਈ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹਾਂ। 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. Мы также можем помочь вам с вспомогательными средствами и альтернативными форматами. 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: Tenemos disponible asistencia en su idioma sin ningún costo 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. También puede solicitar recursos para discapacidades en nuestros centros de atención. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (excepto 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. Maaari ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. 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: มีบริการช่วยเหลือด้านภาษาฟรีตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์ คุณสามารถ ขอใช้บริการล่าม แปลเอกสารเป็นภาษาของคุณ หรือในรูปแบบอื่นได้ คุณสามารถขออุปกรณ์และเครื่องมือช่วยเหลือได้ที่ศูนย์บริการให้ความช่วยเหลือของเรา โดยโทรหา เราที่ **1-800-464-4000** ตลอด 24 ชั่วโมง 7 วันต่อสัปดาห์ (ยกเว้นวันหยุดราชการ) ผู้ใช้ TTY ให้โทร **711**

Ukrainian: Послуги перекладача надаються безкоштовно, цілодобово, 7 днів на тиждень. Ви можете зробити запит на послуги усного перекладача, отримання матеріалів у перекладі мовою, якою володієте, або в альтернативних форматах. Також ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Просто зателефонуйте нам за номером **1-800-464-4000**. Ми працюємо цілодобово, 7 днів на тиждень (крім святкових днів). Номер для користувачів телетайпа: **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 cũng có thể yêu cầu các phương tiện trợ giúp và thiết bị bổ trợ tại các cơ sở của chúng tôi. 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

Discrimination is against the law. Kaiser Permanente[1] follows State and Federal civil rights laws.

Kaiser Permanente does not unlawfully discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Service Contact Center, 24 hours a day, 7 days a week (closed holidays). The call is free:

- Medi-Cal: **1-855-839-7613** (TTY **711**)
- All others: **1-800-464-4000** (TTY **711**)

Upon request, this document can be made available to you in braille, large print, audiocassette, or electronic form. To obtain a copy in one of these alternative formats, or another format, call our Member Service Contact Center and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with Kaiser Permanente if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Medi-Cal members may call **1-855-839-7613** (TTY **711**). All other members may call **1-800-464-4000** (TTY **711**). Help is available 24 hours a day, 7 days a week (closed holidays)
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses)

[1] Kaiser Permanente is inclusive of Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, and the Southern California Medical Group

- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator

Member Relations Grievance Operations

P.O. Box 939001

San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office of Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Deputy Director, Office of Civil Rights
  Department of Health Care Services
  Office of Civil Rights
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  Complaint forms are available at: **http://www.dhcs.ca.gov/Pages/Language_Access.aspx**

- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at:
  https://www.hhs.gov/ocr/complaints/index.html

- **Online:** Visit the Office of Civil Rights Complaint Portal at: **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.**

Complete care to help you live a fuller, healthier life

With Kaiser Permanente, you have a trusted partner who considers your health a priority and makes it easier to get the care you need. That's why members stay with Kaiser Permanente nearly 3 times as long as other health plans.[12]

Want to learn more?

Visit **kp.org/allthatisyou** to shop plans and get help with your health care questions.

Call **1-800-514-0985** (TTY **711**), Monday through Friday, 7 a.m. to 6 p.m. Pacific time to talk to an enrollment specialist.

Current members with questions can call Member Services, 24 hours a day, 7 days a week (closed holidays).

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

2024 National Enrollment Guide

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