Find your healthy place
With care designed to help you thrive

kp.org/thrive
Connected care makes your life easier

We combine care and coverage – which makes us different than your other health care options. Your doctors, hospitals, and health plan work together to make getting the right care more convenient. Your care meets you where you are, because it’s centered around you.
Benefit Summary

100600 UNITE HERE HEALTH_DHMO+

Principal Benefits for
Kaiser Permanente Deductible HMO Plan (1/1/21—12/31/21)

Accumulation Period

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

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

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

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

<table>
<thead>
<tr>
<th>Amounts Per Accumulation Period</th>
<th>Self-Only Coverage (a Family of one Member)</th>
<th>Family Coverage Each Member in a Family of two or more Members</th>
<th>Family Coverage Entire Family of two or more Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Out-of-Pocket Maximum</td>
<td>$3,000</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>Plan Deductible</td>
<td>$1,000</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>Drug Deductible</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

Professional Services (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)

Family planning counseling and consultations................................................................. No charge (Plan Deductible doesn’t apply)

Scheduled prenatal care exams......................................................................................... No charge (Plan Deductible doesn’t apply)

Routine eye exams with a Plan Optometrist.................................................................... No charge (Plan Deductible doesn’t apply)

Urgent care consultations, evaluations, and treatment..................................................... $20 per visit (Plan Deductible doesn’t apply)

Most physical, occupational, and speech therapy ......................................................... $20 per visit (Plan Deductible doesn’t apply)

Outpatient Services

You Pay

Outpatient surgery and certain other outpatient procedures.......................................... 20% Coinsurance after Plan Deductible

Allergy antigens (including administration).................................................................. No charge (Plan Deductible doesn’t apply)

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)

Hospitalization Services

You Pay

Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs.................... 20% Coinsurance after Plan Deductible

Emergency Health Coverage

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 “Hospitalization 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 at a Plan Pharmacy.......................................................................... $10 for up to a 30-day supply (Plan Deductible doesn’t apply)

Most generic refills through our mail-order service...................................................... $20 for up to a 100-day supply (Plan Deductible doesn’t apply)

Most brand-name items at a Plan Pharmacy................................................................. $30 for up to a 30-day supply (Plan Deductible doesn’t apply)

Most brand-name refills through our mail-order service............................................... $60 for up to a 100-day supply (Plan Deductible doesn’t apply)

Most specialty items 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

4177314.44.1.S000607585 - DHMO + COMPOSITE - EU 10 (continues)
## Benefit Summary

### Mental Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual outpatient mental health evaluation and treatment</td>
<td>$20 per visit (Plan Deductible doesn’t apply)</td>
</tr>
<tr>
<td>Group outpatient mental health treatment</td>
<td>$10 per visit (Plan Deductible doesn’t apply)</td>
</tr>
</tbody>
</table>

### Substance Use Disorder Treatment

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient detoxification</td>
<td>20% Coinsurance after Plan Deductible</td>
</tr>
<tr>
<td>Individual outpatient substance use disorder evaluation and treatment</td>
<td>$20 per visit (Plan Deductible doesn’t apply)</td>
</tr>
<tr>
<td>Group outpatient substance use disorder treatment</td>
<td>$5 per visit (Plan Deductible doesn’t apply)</td>
</tr>
</tbody>
</table>

### Home Health Services

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care (up to 100 visits per Accumulation Period)</td>
<td>No charge (Plan Deductible doesn’t apply)</td>
</tr>
</tbody>
</table>

### Other

<table>
<thead>
<tr>
<th>Service</th>
<th>You Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skilled nursing facility care (up to 100 days per benefit period)</td>
<td>20% Coinsurance (Plan Deductible doesn’t apply)</td>
</tr>
<tr>
<td>Prosthetic and orthotic devices as described in the EOC</td>
<td>No charge (Plan Deductible doesn’t apply)</td>
</tr>
<tr>
<td>Diagnosis and treatment of infertility and artificial insemination</td>
<td>50% Coinsurance (Plan Deductible doesn’t apply)</td>
</tr>
<tr>
<td>Assisted reproductive technology (“ART”) Services</td>
<td>Not covered</td>
</tr>
<tr>
<td>Hospice care</td>
<td>No charge (Plan Deductible doesn’t apply)</td>
</tr>
</tbody>
</table>

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).
Go where you feel like your best self

We can help you get to your healthy place – no matter where it is. Care at Kaiser Permanente feels easier and faster, with the help of connected caregivers, more ways to get care at home or on the go, and support for your total health. Welcome to care that fits your life.

A better experience from the start .............................................................................................................4
Quality care with you at the center ..............................................................................................................5
Great care, great results .................................................................................................................................6
Convenient ways to get care ..........................................................................................................................7
Healthy resources ...........................................................................................................................................8
Care when and where you need it ...................................................................................................................9

To sign up, contact your employer or call us at 1-800-464-4000 (TTY 711). We’re available 24 hours a day, 7 days a week (closed holidays). Visit kp.org/thrive to see how we make your care experience better.
A better experience from the start

We guide you through each step of joining Kaiser Permanente, so you can start getting the care you need in no time.

Ready to get started? Visit kp.org/newmember.

Choose a doctor who’s right for you
Our online doctor profiles let you browse the many excellent doctors and convenient locations in your area, even before you enroll. So you can join knowing you’ve found a doctor who fits your needs. You’re also free to change at any time, for any reason.

Transition your care seamlessly
Easily move prescriptions and find a location that’s close to your home, work, or school. Many services are often under one roof, making it easy to see your doctor, get a lab test, and pick up prescriptions — all in one trip.

Get care on your schedule
Need to schedule an appointment? Have a nonurgent question you’d like to email to your doctor’s office? Want your prescription refill mailed to your home? After you enroll, register for an online account at kp.org or get our mobile app. Then join the millions of members who easily manage their health online — whenever, wherever.

Want to talk? We’re here to help.
You don’t have to choose a health plan alone. A Kaiser Permanente enrollment specialist can answer your questions – like where to get care or what extra perks are included. Call 1-800-324-9208 (TTY 711), Monday through Friday, 7 a.m. to 6 p.m. Pacific time.
Quality care with you at the center

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

Great care from great doctors

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

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

Better care with a connected team

Your doctor, nurses, and other specialists are connected to each other, and to you, through your electronic health record. So they know important things about you and your health — like when you’re due for a screening and what medications you’re taking. That way, you get personalized care that’s right for you.

Personalized care for all members

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

• Strive to hire doctors and staff who speak more than one language
• Offer telephone interpretation services in more than 150 languages
• Train our care teams on how to connect with and care for people of diverse backgrounds
• Improved health outcomes among diverse populations for conditions like high blood pressure, diabetes, and colon cancer¹

Get an idea of what you’ll pay before you come in for care with a personalized cost estimate based on your plan details.
Great care, great results

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

Preventive care to keep you healthy

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

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

Support for ongoing conditions

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

Specialty care when you need it

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

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

A leader in clinical quality

In 2019, Kaiser Permanente led the nation as the top performer in 26 effectiveness-of-care measures – the most of any health plan. These measures include:

- Prevention and screening
- Cardiovascular care
- Comprehensive diabetes care
- Mental health
- Maternity care

Hear care stories from real Kaiser Permanente members at kp.org/carestories.
# Convenient ways to get care

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

## Choose how you get care

### Video
Want a convenient, secure way to see a doctor wherever you are? Meet face-to-face online. Ask your doctor if video visits are available to you.

### Phone
Have a condition that doesn’t require an in-person exam? Save yourself a trip to the office by scheduling a call with a Kaiser Permanente clinician.

### In person
Visit your doctor for routine care, preventive services, care when you’re not feeling well, and more. You may also be able to schedule same-day appointments.

## Other ways to get care in the moment

### E-visit
Fill out a short questionnaire about your symptoms online and get personalized self-care advice from a Kaiser Permanente provider.

### 24/7 care and advice by phone
Call us for advice when you need it most. We’ll help you find out what care is right for you, schedule appointments, and more.

### Email
Message your doctor’s office anytime with nonurgent health questions. You’ll get a response usually within 2 business days, if not sooner.

### App
Download the Kaiser Permanente app to manage routine appointments, refill most prescriptions for mail-order delivery, see most test results, and more. You can also keep up with your care at [kp.org](http://kp.org).
Healthy resources

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

Get the most out of your membership perks

- **Special rates for members**
  Enjoy reduced rates on services that can help you stay healthy – like gym memberships, acupuncture, massage therapy, and chiropractic care.

- **Self-care apps**
  Navigate mental and emotional challenges and help improve your sleep, mood, relationships, and more with the help of wellness apps, available at no cost to adult members. Visit [kp.org/selfcareapps](http://kp.org/selfcareapps).

- **Healthy lifestyle programs**
  Connect to better health with online programs to help you lose weight, quit smoking, reduce stress, and more – all at no cost. Learn more at [kp.org/healthylifestyles](http://kp.org/healthylifestyles).

- **Personal wellness coaching**
  Get help reaching your health goals. Work one-on-one with a wellness coach by phone at no cost. Find out more at [kp.org/wellnesscoach](http://kp.org/wellnesscoach).

- **Online wellness tools**
  Visit [kp.org/healthyliving](http://kp.org/healthyliving) for wellness information, health calculators, fitness videos, podcasts, and recipes from world-class chefs.

- **Health classes**
  Sign up for health classes and support groups at many of our facilities. See what’s available near you at [kp.org/classes](http://kp.org/classes) – some may require a fee.

- **Seasonal farmers markets**
  Shop for local produce, fresh flowers, and more at farmers markets at many of our facilities. Learn more and find healthy recipes at [kp.org/foodforhealth](http://kp.org/foodforhealth).
Care when and where you need it

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

Convenient care near you

With multiple locations to choose from, it’s easy to find one near home or work. You can see your doctor, visit the pharmacy, and get a lab test under one roof at most of our facilities. We offer same-day, next-day, after-hours, and weekend services at many of our locations, along with ob-gyn, pediatrics, and other specialty departments. You can also see different doctors at different locations – whatever works best for you.

Finding the right location

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

- Visit kp.org/facilities to search by ZIP code, keyword, or the type of service you need.
- Search on your smartphone with the location finder on the Kaiser Permanente mobile app.8

Getting care anytime, anywhere

Urgent care9

Many facilities offer services for nonemergency, urgent medical needs that require immediate attention – open 7 days a week.10

Emergency care

If you ever need emergency care, you’re covered. You can always get care at any Kaiser Permanente or non–Kaiser Permanente hospital emergency department.11

Care away from home

If you get hurt or sick while traveling, we’ll help you get care. We can also help you before you leave town by checking to see if you need a vaccination, refilling prescriptions, and more. Just call our 24/7 Away from Home Travel Line12 at 951-268-3900 or visit kp.org/travel.

See the following pages for location maps and a list of new medical facility openings in your area.
What’s new in Northern California

Care Essentials in downtown San Francisco
Our innovative new offering centered on convenience will be located at the Salesforce Transit Center with extended hours for our busy downtown commuters. Services include same-day appointments, pharmacy, lab tests, vaccines, injections, and treatment of minor illnesses and injuries. Scheduled to open late 2020.

Mental health and wellness locations
We’re committed to your total health and focused on expanding our mental health offerings in 2020.
- Fresno Spruce Medical Offices – adult and family medicine, mental health services, pharmacy, lab, and X-ray services (scheduled to open fall 2020)
- Oakland Clay Street Mental Health & Wellness (now open)
- San Francisco Ellis Street Mental Health & Wellness (scheduled to open summer 2020)
- Watsonville Mental Health & Wellness (scheduled to open summer 2020)
- Modesto Enterprise Mental Health & Wellness (scheduled to open fall 2020)
- Scotts Valley Mental Health & Wellness (scheduled to open fall 2020)

New medical offices
With more convenient locations and doctors to choose from, it’s easier to get the care you need.
- Fresno Cedar Avenue Medical Offices – adult medicine (now open)
- Alameda Medical Offices expansion – radiology and mammography (scheduled to open summer 2020)
What’s new in Southern California

Clairemont Mesa Medical Offices
Relocation of this facility includes primary and specialty care, allergy, dermatology, family medicine residency program, family medicine, internal medicine, laboratory, nurse clinic, pediatric endocrinology/diabetes clinic, pediatric John Richards Learning Center, pediatrics, pharmacy, radiology/diagnostic imaging, and Vision Essentials (optometry/optical center). Scheduled to open summer 2020.

Playa Vista Medical Offices
Relocation of this facility includes adult primary care, Center for Healthy Living, complete care nurse clinic, laboratory, mammography, behavioral health, obstetrics-gynecology, occupational health, pediatrics, pharmacy, and radiology. Scheduled to open July 2020.

Aliso Creek Medical Offices
Relocation of this facility includes primary and specialty care. Scheduled to open early 2021.

Hesperia Medical Offices
New medical office with primary and specialty care. Scheduled to open early 2021.

Downey Medical Center
Expansion of existing hospital tower and its services. Scheduled to open spring 2021.

Covina Medical Offices
New facility with adult primary care, mental health, speech therapy, nurse clinic, obstetrics-gynecology, pediatrics, pharmacy, and radiology. Scheduled to open late 2021.
Hospital Services
Deductible HMO Plan

With this Kaiser Permanente health plan, you get a wide range of care and support to help you stay healthy and get the most out of life. It has a deductible, but only for hospital services. For lab services, radiology, and doctor’s office visits, you pay a copay or coinsurance even before you reach your deductible. And preventive care services – like routine physical exams, mammograms, and cholesterol screenings – are covered at no cost or at a copay.*

You pay copays or coinsurance for doctor’s office visits and prescription drugs.

Preventive care services are covered at no cost or at a copay.*

After you reach your deductible, other services are available at a copay or coinsurance.

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

Our personalized online Estimates tool gives you a better understanding of what you’ll pay for care so you can plan ahead.

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

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

Know what to expect with useful tools that help you understand when and how much you can expect to pay. This makes it easier for you to manage your care and get the most out of your plan.

Limits on how much you pay for care

When you get care, you’ll pay a copay or a percentage of the charges (a coinsurance) for most services. For hospital services, you’ll pay the full charges until you reach a set amount, known as your deductible. Then you’ll start paying less – a copay or coinsurance – for hospital services for the rest of the year.

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

Limits on how much your family pays

If your family is covered under your plan, you also have a family deductible and out-of-pocket maximum. When you reach your family deductible, everyone will start paying copays or coinsurance for covered services instead of the full charges. If a family member reaches their individual deductible first, they’ll start paying copays or coinsurance before the rest of the family.

If you reach your family out-of-pocket maximum, no one in your family will pay for most covered services for the rest of the year. And if any family members reach their individual out-of-pocket maximums before the rest of the family, they won’t have to pay for most covered services for the rest of the year.

Care away from home

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

Deductible
The amount you pay each year for covered services before Kaiser Permanente starts paying.
Example: If you have a $500 deductible, you’ll pay the full charges up to $500 before you start paying copays or coinsurance.

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

*This number can be dialed inside and outside the United States. Before the phone number, dial “001” for landlines and “+1” for mobile lines if you’re outside the country. Long-distance charges may apply, and we can’t accept collect calls. The phone line is closed on major holidays (New Year’s Day, Easter, Memorial Day, July Fourth, Labor Day, Thanksgiving, and Christmas). It closes early the day before a holiday at 10 p.m. Pacific time (PT), and it reopens the day after a holiday at 4 a.m. PT.
For details about your deductible, copays, coinsurance, and out-of-pocket maximum, see the Disclosure Form Part One at the front of this book. For other details about your plan, see the Disclosure Form Part Two at the back of this book or ask your benefits manager for your Evidence of Coverage.

Know before you go

Knowing what you can expect to pay for certain services can help you plan ahead for the care you need. Once you’re a member, you can register on kp.org, where you can get a personalized estimate for over 500 services using our Estimates tool. It also shows how close you are to reaching your deductible and out-of-pocket maximum.

How payments work

When you come in for care, 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 additional services during your visit. In that case, you’ll get a bill later for the difference.

For more information, including resources for managing your costs, visit kp.org/deductibleplans.

Coinsurance

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

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

Your prescription drug coverage

Generic, brand-name, and specialty drugs are covered at a copay or coinsurance. If your plan has a separate deductible for prescription drugs, you’ll need to reach your drug deductible before you begin to pay a copay or coinsurance. See the Disclosure Form Part One at the front of this book for details on your prescription coverage.

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

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

Out-of-pocket maximum

The maximum amount you’ll pay for covered services each year. For a small number of services, such as durable medical equipment and fertility services, you may need to keep paying copays or coinsurance after reaching your out-of-pocket maximum.

Example: If you have a $3,000 out-of-pocket maximum and you reach it before the year’s end, you’ll pay no charges for most covered services for the rest of the year.
Understanding your costs during preventive care visits

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

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

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

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

**Treatment or testing for existing conditions**
If you’re taking a new medication, your doctor might order a lab test to see if it’s working and make sure you’re on the right dose.

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

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

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

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

For women
• Breastfeeding support, supplies, and counseling
• Prenatal care
• Routine mammograms
• Routine Pap tests

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

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

How do I pay for non-preventive services?

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

Have questions about your costs or bills?

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

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

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

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

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

Understanding your costs

With your deductible plan, you’ll pay the full charges for covered services until you reach your deductible. Then you’ll start paying less – a copay or a coinsurance.* These steps show what to expect before, during, and after your visit – so you can avoid surprises and better understand and manage your health care costs.

1 Before your visit
Get an estimate
Visit kp.org/costestimates for an estimate of what you’ll pay for common services. Estimates are based on your plan benefits and whether you’ve reached your deductible – so you get personalized information every time.

You can also call 1-800-390-3507, weekdays from 7 a.m. to 5 p.m.

2 During your visit
Pay when you check in
When you come in for care, you’ll be asked to make a payment for your scheduled services.†

Your payment may only cover part of what you owe for your visit, especially if you get any additional services. In that case, you’ll get a bill for the difference later.

3 After your visit
Understand your bills
You’ll get a bill after most visits. It will show the charges for the services you got, what you paid, what your health plan paid, and the amount you owe.

You can pay your bill:
• Online anytime at kp.org/paymedicalbills
• On the Kaiser Permanente app
• By mail
• By phone at 1-800-390-3507, weekdays from 7 a.m. to 5 p.m.

Visit kp.org/deductibleplans
You’ll find a wide range of information and resources to help you understand your plan and manage your costs.

Expect a bill for additional services
During your visit, your doctor may decide you also need services that weren’t scheduled – like a blood test or an X-ray. If what you pay for these services doesn’t cover everything you owe, you’ll get a bill later.

Track your expenses
You’ll also get an Explanation of Benefits (EOB). It isn’t a bill. It’s a summary of your services and charges, and shows how close you are to reaching your deductible and out-of-pocket maximum. Visit kp.org/mydocuments anytime to see your EOBs online.

See the next page for important terms and more information about services that can result in a bill.

*Depending on your plan, you may pay copays or coinsurance for some services without having to reach your deductible.
†If your plan comes with a flexible spending account (FSA), health reimbursement arrangement (HRA), or health savings account (HSA), you can pay using the debit card for your account, if you have one. Use it when you check in for your visit or when paying your bill later.
When a preventive visit includes non-preventive care

Preventive care services are an important part of catching health problems early – that’s why they’re covered at no cost or at a copay.* But sometimes when you come in for preventive care, you’ll get non-preventive services too, which you’ll need to pay for.

For example, during a routine physical exam, your doctor might find a mole and remove it for testing. Because the mole removal and testing are non-preventive services, you’ll get a bill for them later.

Have questions or need help paying for care?

Call 1-800-390-3507, weekdays from 7 a.m. to 5 p.m., if you have questions about your costs or bills. You can also get information about financial assistance and payment options available for members who need help paying for care.

### Important terms

**Deductible**
The amount you pay for covered services each year before your health plan starts paying. Depending on your plan, you may pay copays or coinsurance for some services without having to reach your deductible.

**Copay**
The set amount you pay for covered services. For example, a $10 copay for an office visit.

**Coinsurance**
A percentage of the charges that you pay for covered services. For example, a 20% coinsurance for a $200 procedure means you pay $40.

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

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* Depending on your plan, preventive care services are covered at no cost or at a copay. For more information, see your Evidence of Coverage or Summary Plan Description.

† If you have an HSA-qualified deductible plan, once you reach your out-of-pocket maximum, you won’t have to pay anything for covered services for the rest of the year. If you are enrolled through a group’s self-funded EPO plan, your health benefits are self-insured by your employer, union, or Plan sponsor. Kaiser Permanente Insurance Company provides certain administrative services for the Plan and is not an insurer of the Plan or financially liable for health care benefits under the Plan.
Nondiscrimination Notice

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

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

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

You may submit a grievance in the following ways:

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

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

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1–800–368–1019, 800–537–7697 (TDD). Complaint forms are available at hhs.gov/ocr/office/file/index.html.
Aviso de no discriminación

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

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

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

Puede presentar una queja de las siguientes maneras:

• Completando un formulario de queja o de reclamación/solicitud de beneficios en una oficina de Servicio a los Miembros ubicada en un centro del plan (consulte las direcciones en Su Guía o en el directorio de centros de atención en nuestro sitio web en kp.org/espanol)

• Enviando por correo su queja por escrito a una oficina de Servicio a los Miembros en un centro del plan (consulte las direcciones en Su Guía o en el directorio de centros de atención en nuestro sitio web en kp.org/espanol)

• Llamando a la línea telefónica gratuita de la Central de Llamadas de Servicio a los Miembros al 1-800-788-0616 (los usuarios de la línea TTY deben llamar al 711)

• Completando el formulario de queja en nuestro sitio web en kp.org/espanol

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

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

無歧視公告

Kaiser Permanente禁止以年齡、人種、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達、性取向、婚姻狀況、生理或心理殘障、付款來源、遺傳資訊、公民身份、主要語言或移民身份為由而歧視任何人。

會員服務聯絡中心每週七天每天24小時提供語言協助服務（節假日除外）。本機構在全部營業時間內免費為您提供口譯，包括手語服務，以及殘障人士輔助器材和服務。我們還可為您和您的親友提供使用本機構設施與服務所需要的任何特別協助。您還可免費索取翻譯成您的語言的資料，以及符合您需求的大號字體或其他格式的版本。若需更多資訊，請致電 1-800-757-7585（TTY專線使用者請撥711）。

申訴指任何您或您的授權代表透過申訴程序來表達不滿的做法。例如，如果您認為自己受到歧視，即可提出申訴。若需瞭解適用於自己的爭議解決選項，請參閱《承保範圍說明書》(Evidence of Coverage)或《保險證明書》(Certificate of Insurance)，或諮詢會員服務代表。如果您是Medicare、Medi-Cal、高風險醫療保險計劃(Major Risk Medical Insurance Program, MRMIP)、Medi-Cal Access、聯邦僱員健康保險計劃(Federal Employees Health Benefits Program, FEHBP)或CalPERS會員，採取上述行動尤其重要，因為您可能有不同的爭議解決選項。

您可透過以下方式提出申訴：
• 在健康保險計劃服務設施的會員服務處填寫《投訴或福利索賠/申請表》（地址見《健康服務指南》(Your Guidebook)或我們網站kp.org上的服務設施名錄）
• 將書面申訴信郵寄到健康保險計劃服務設施的會員服務處（地址見《健康服務指南》或我們網站kp.org上的服務設施名錄）
• 致電我們的會員服務聯絡中心，免費電話號碼是1-800-757-7585（TTY專線請撥711）
• 在我們的網站上填寫申訴表，網址是kp.org

如果您在提交申訴時需要協助，請致電我們的會員服務聯絡中心。

涉及人種、膚色、原國籍、性別、年齡或殘障歧視的一切申訴都將通知Kaiser Permanente的民權事務協調員。您也可與Kaiser Permanente的民權事務協調員直接聯絡，地址：One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612。

Thông Báo Khỏng Kỳ Thiế

Kaiser Permanente không phân biệt đối xử dựa trên tuội tác, chúng tọc, sắc tộc, màu da, nguyên quán, hoàn cảnh vân hoa, tổ tiên, tôn giáo, giới tính, nhân dạng giới tính, cách thể hiện giới tính, khuynh hướng tính dục, gia cảnh, khuyết tật về thể chất hoặc tính thần, nguồn tiến thân, truyền, quốc tịch, ngôn ngữ chính, hay tin tưởng di truyền.

Các dịch vụ trợ giúp ngôn ngữ hiện có từ Trung Tấm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi 24 giờ trong ngày, báy ngày trong tuần (người trả ngày lê). Dịch vụ thông dịch, kế cả ngôn ngữ ký hiệu, được cung cấp miễn phí cho quý vị trong giờ làm việc. Các phương tiện trợ giúp và dịch vụ bố sung cho những người khuyết tật được cung cấp miễn phí cho quý vị trong giờ làm việc. Chứng tôi cũng có thể cung cấp cho quý vị, gia đình và bạn bè quý vị mọi hỗ trợ đặc biệt cần thiết để sử dụng cơ sở và dịch vụ của chúng tôi. Quý vị có thể yêu cầu liệu được dịch ra ngôn ngữ của quý vị, và cũng có thể yêu cầu miễn phí các tài liệu này dưới dạng chữ lớn hoặc dưới các dạng khác để đáp ứng nhu cầu của quý vị. Để biết thêm thông tin, gọi 1-800-464-4000 (người dùng TTY gọi 711).


Quý vị có thể nộp đơn than phiền bằng các hình thức sau đây:

- Điền đơn Khởi Nại hoặc Yêu Cầu/Điều Quyền Lợi tại văn phòng ban Dịch Vụ Hội Viên tại một Cơ Sở Thuốc Chướng Trình (xin tham khảo Sách Hướng Dẫn của Quý Vị hoặc danh bạ cơ sở trên trang mạng của chúng tôi tại kp.org để biết địa chỉ)
- Gửi đơn than phiền tới văn phòng ban Dịch Vụ Hội Viên tại một Cơ Sở Thuốc Chướng Trình (xin tham khảo Sách Hướng Dẫn của Quý Vị hoặc danh bạ cơ sở trên trang mạng của chúng tôi tại kp.org để biết địa chỉ)
- Gửi số miễn phí của Trung Tấm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi tại 1-800-464-4000 (người dùng TTY gọi 711)
- Điền đơn than phiền trên trang mạng của chúng tôi tại kp.org

Xin gửi Trung Tấm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi nếu quý vị cần trợ giúp nộp đơn than phiền.

Diệu Phơi Viên Dân Quyền (Civil Rights Coordinator) Kaiser Permanente sẽ được thông báo về tất cả khiếu nại liên quan tối việc kỳ thị trên cơ sở chúng tộc, màu da, nguyên quán, giới tính, tuổi tác, hay tin tưởng di truyền. Quy vị cũng có thể liên lạc trực tiếp với Diệu Phơi Viên Dân Quyền Kaiser Permanente tại One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612.

Language Assistance Services

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

Arabic: ترجمة لغوية متوفرة مجانًا مدار الساعة كافة أيام الأسبوع، بإمكانك طلب ترجمة لغوية أو ترجمة منشورة طلباً لغك، أو طلب إرسال المحتوى مترجم إلى لغتك في أي وقت خلال أيام الأسبوع. تمكين خدماتك مترجمة مع مترجمين مختصين في اللغة، أو طلب إرسال المحتوى مترجم إلى لغتك، أو طلب إرسال المحتوى مترجم إلى لغتك في أي وقت خلال أيام الأسبوع. تمكين خدماتك مترجمة مع مترجمين مختصين في اللغة.


Chinese: 每週7天，每天24小時均可獲得免費語言協助。您可以申請口語服務、請求資料翻譯或申請您所選語言或文字轉換為其他格式。我們每天7天，每天24小時均可為您提供電話服務：1-800-757-7585（節假日除外）。聽障及語障專線（TTY使用者）請撥711。

Farsi: خدمات زبانی در 24 ساعت شبانه‌روز و 7 روز هفته بدون اخذ هزینه در اختیار شما است. شما می‌توانید برای خدمات ترجمه صحافی، ترجمه اطلاعات زبانی و یا به صورت های دیگر درخواست کنید. کافی‌ست در 24 ساعت شبانه‌روز و 7 روز هفته 1-800-464-4000 به استناد روزهای تعطیل با ما همراه شوید. تماس بگیرید کاربران TTY بشرح 711 تماس بگیرید. یا به شماره 711 تماس بگیرید.


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、日本語翻訳を軽く利用できる資料、あるいは資料を別の書式でも依頼できます。お気軽にお問い合わせください（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: គ្រួសារមន្ត្រី និងការបរិច្ឆេះអំពីការសំណួស 24 ទឹក្សាដ៏ទឹក្សាដ៏ 7 ឈឺធូរភាសាដ៏ 7 ឈឺធូរភាសាដ៏ តំណាងពាក្យជាអនុគម្រឹងវិមាត្រ ការសំណួសក្នុងប្រហីរជាអនុគម្រឹងវិមាត្រ ជាក្រុមហ៊ុនអនុគម្រឹងវិមាត្រ ត្រូវបានផ្តល់ឱ្យដ៏ ការសំណួស 24 ទឹក្សាដ៏ 7 ឈឺធូរភាសាដ៏ 7 ឈឺធូរភាសាដ៏ TTY ទឹក្សាលេ TTY 711។


Laotian: ການសັ່ງເສັດຕະຫຼາດຈາກສາມາດໂທລາຍໃດທີ່ເມືອງ 24 ໂຊບຊາດ 7 ວັນຊາດກັນ. ແຕ່ນີ້ ການສັ່ງເສັດຕະຫຼາດຈາກສາມາດໂທລາຍໃດທີ່ເມືອງ 24 ໂຊບຊາດ 7 ວັນຊາດກັນ. ແຕ່ນີ້ ການສັ່ງເສັດຕະຫຼາດຈາກສາມາດໂທລາຍໃດທີ່ເມືອງ 24 ໂຊບຊາດ 7 ວັນຊາດກັນ. ແຕ່ນີ້ ການສັ່ງເສັດຕະຫຼາດຈາກສາມາດໂທລາຍໃດທີ່ເມືອງ 24 ໂຊບຊາດ 7 ວັນຊາດກັນ. ແຕ່ນີ້ ການສັ່ງເສັດຕະຫຼາດຈາກສາມາດໂທລາຍໃດທີ່ເມືອງ 24 ໂຊບຊາດ 7 ວັນຊາດກັນ. ແຕ່ນີ້ ການສັ່ງເສັດຕະຫຼາດຈາກສາລະດອກຂອງ 1-800-464-4000, 24 ໂຊບຊາດ 7 ວັນຊາດກັນ. 7 ວັນຊາດກັນ. (ປິດວັນພະຫົນ). TTY ການສັ່ງເສັດຕະຫຼາດ 711.
Navajo: Saad bee áká’a ayed náhóló t’áá jiik’é, naadiin doo bibqą’ dij’ ahéé’iikeed tsosts’id yiskáajj damoo ná’ádleehjí. Atah halné’e áká’adoowlolíí dij’o’, éí doodai’ nááná lá a’la’ ádaat’ehigii bee hádádílyaa’go. Kojí hodíilnih 1-800-464-4000, naadiin doo bibqą’ dij’ ahéé’iikeed tsosts’id yiskáajj damoo ná’ádleehjí (Dahodiyin biniyé e’e’aa‘ho éi da’deeklaa).

TTY chodeeyoolínígíí kojí hodíilnih 711.

Punjabi: ਬਿਨ ਾਂ ਬਿਸੀ ਲ ਗਤ ਦੇ, ਬਦਨਵਾਂ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਬਦਨਵਾਂ, ਦੁਆਂਜਾਂ ਸੀਆਂ ਸੇਵਾ ਵਾਂ ਤੁਹਦੇ ਲਈ ਉਪਲਿਧ ਹੈ। ਤੁਸੀਂ ਇੱਕ ਬਦਨਵਾਂ ਦੀ ਮਦਦ ਲਈ, ਸਮੱਗਰੀਆਂ ਨਾਂ ਆਪਣੀ ਭਵਿੱਧ ਅਨੁਵਾਦ ਦੀ ਭਵਿੱਧ ਨੰਦ ਬਵਾਕਾਰ ਪਰ ਪਤਨੀ ਲਈ ਜਾਂ ਬਿਸੇਵਾਂ ਫਰਮਾਟ ਬਵਾਕਾਰ ਪਰ ਪਤਨੀ ਲਈ ਹੋ।

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

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

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

Thai: เราให้บริการแปลภาษาฟรี 24 ชั่วโมง ทุกวันตลอดซึ่งให้การบริการของเราสามารถให้คำแนะนำที่แม่นยำและมีคุณค่า 24 ชั่วโมงทุกวัน (โปรดให้บริการในวันหยุดราชการ) ผู้ใช้ TTY โปรดโทรไปที่ 711.

Vietnamese: Dịch vụ thông dịch được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. Quý vị chỉ cần gọi cho chúng tôi tại số 1-800-464-4000, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi 711.
1. Kaiser Permanente improved blood pressure control in our black/African-American members with hypertension, raised colorectal cancer screening rates in our Hispanic/Latino members, and improved blood sugar control in our members with diabetes. Self-reported race and ethnicity data are captured in KP HealthConnect, and HEDIS® measures are updated quarterly in the interregional CORE Datamart. 2. Kaiser Permanente 2019 HEDIS® scores. Benchmarks provided by the National Committee for Quality Assurance (NCQA) Quality Compass® and represent all lines of business. Kaiser Permanente combined region scores were provided by the Kaiser Permanente Department of Care and Service Quality. The source for data contained in this publication is Quality Compass 2019 and is used with the permission of NCQA. Quality Compass 2019 includes certain CAHPS® data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass® and HEDIS® are registered trademarks of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality. 3. When appropriate and available. 4. These features are available when you get care from Kaiser Permanente facilities. 5. To use the Kaiser Permanente app, you must be a Kaiser Permanente member registered on kp.org. 6. These services aren't covered under your health plan benefits and aren't subject to the terms set forth in your Evidence of Coverage or other plan documents. These services may be discontinued at any time without notice. 7. In the case of a pandemic, some facilities may be closed or offer limited hours and services. 8. See note 5. 9. An urgent care need is one that requires prompt medical attention, usually within 24 or 48 hours, but is not an emergency medical condition. This can include minor injuries, backaches, earaches, sore throats, coughs, upper-respiratory symptoms, and frequent urination or a burning sensation when urinating. 10. See note 7. 11. If you believe you have an emergency medical condition, call 911 or go to the nearest hospital. For the complete definition of an emergency medical condition, please refer to your Evidence of Coverage or other coverage documents. 12. This number can be dialed inside and outside the United States. Before the phone number, dial “001” for landlines and “+1” for mobile lines if you’re outside the United States. Long-distance charges may apply, and we can’t accept collect calls. The phone line is closed on major holidays (New Year’s Day, Easter, Memorial Day, July Fourth, Labor Day, Thanksgiving, and Christmas). It closes early the day before a holiday at 10 p.m. Pacific time (PT), and it reopens the day after a holiday at 4 a.m. PT.
Disclosure Form Part Two for Kaiser Permanente Traditional Plans And Deductible Plan
Language Assistance Services

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

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

Armenian: Ձեզ կարող է անվճար օգնություն տրամադրվել լեզվի հարցում `օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Պարզապես զանգահարեք մեզ 1-800-464-4000 հեռախոսահամարով `օր 24 ժամ` շաբաթը 7 օր (սապր օրինակ փոխել է): TTY-ից ուղարկեք պաշտոնական յուրաքանչյուր 711:

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

Farsi: در زبانی خدمات 24 ساعت شبانروز و 7 بدون روز هفته متناسبه. شما می توانید برای اخذ خدمات متجم تلفن در 24 ساعت شبانروز و 7 بدون روز هفته 1-800-464-4000 تماس بگیرید. کاربران TTY شماره 711 تلفن نشانگری.
Navajo: Saad bee áká’á ayeed náhóló t’áá jiikt’é, naadiin doo bibąą’ dij’é ahéé’iikeed tsosts’id yiskáají damoo ná’ádleehjí. Atah halné’é aká’adoolwolígíí jokí, t’áado le’é t’áá háhazaadjí hadilyáquat’o, éí doodai’ nánán lá al’aq ádaat’ehigii bee hádadilya’a’go. Kojí hodiilnih 1-800-464-4000, naadiin doo bibąą’ dij’é ahéé’iikeed tsosts’id yiskáají damoo ná’ádleehjí (Dahodiyin biniyé e’e’aahgo éi da’deelkaal). TTY chodeeyoolínígíí kojí hodiilnih 1-800-464-4000, naadiin doo bibąą’ dij’é ahéé’iikeed tsosts’id yiskáají damoo ná’ádleehjí (Dahodiyin biniyé e’e’aahgo éi da’deelkaal).

Punjabi: ਬਿਨ ਾਂ ਬਿਸੀ ਲ ਗਤ ਦੇ, ਬਦਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਬਦਨ ਦੀ ਮਦਦ ਲਈ ਉਪਲਿਧ ਹੈ। ਤੁਸੀਂ ਇੱਕ ਸੀਏ ਦੀ ਮਦਦ ਲਈ, ਸਮੱਗਰੀਆਂ ਨਾਂ ਸਾਲ ਅਨੁਵਦ ਪਰ ਪਤਨੀ ਲਈ ਸਹਾਇਤਾ ਹੋ। ਤਸਰਸ ਵੀ ਸੀਆਦ ਦੀ ਮਦਦ ਲਈ, ਜ ਾਂ ਬਿਸੇ ਵੱਖ ਇੱਕ ਲਈ ਸਹਾਇਤਾ ਹੋ।

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

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

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

Thai: เราให้บริการแปลหรือสร้างเอกสาร 24 ชั่วโมง ทุกวันตลอดเวลาทางการของเจ้าหน้าที่สามารถให้คำแนะนำคุณภาพคุณค่าของการสื่อสารของเจ้าหน้าที่และคุณสมบัติสามารถใหม่ให้การแปลเอกสาร ระบบที่มีความหมายได้อย่างถูกต้องในบริการพื้นฐานโทรทัศน์ที่มีรายการ 1-800-464-4000 ตลอด 24 ชั่วโมงทุกวัน (เพื่อให้บริการในวันหยุดราชการ) ผู้ใช้ TTY โปรดโทรไปที่ 711.

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

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

Language assistance services are available from our Member Service Contact Center 24 hours a day, 7 days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. Auxiliary aids and services for individuals with disabilities are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. You may request materials translated in your language at no cost to you. You may also request these materials in large text or in other formats to accommodate your needs at no cost to you. For more information, call 1-800-464-4000 (TTY 711).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your Evidence of Coverage or Certificate of Insurance or speak with a Member Services representative for the dispute-resolution options that apply to you.

You may submit a grievance in the following ways:

- **By phone**: Call member services at 1-800-464-4000 (TTY 711) 24 hours a day, 7 days a week (except closed holidays).
- **By mail**: Call us at 1-800-464-4000 (TTY 711) and ask to have a form sent to you.
- **In person**: Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at kp.org/facilities for addresses)
- **Online**: Use the online form on our website at kp.org

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

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at:

**Northern California**
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

**Southern California**
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

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

This Disclosure Form provides an overview of some of the important features of your Kaiser Permanente membership.

These documents are only a summary of your Health Plan coverage. For details about the terms and conditions of coverage, please 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." Please refer to Your Benefits (Disclosure Form Part One) to learn which California Region is your Home Region. This Disclosure Form describes your coverage in your Home Region.

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

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

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

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

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

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

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

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

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

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

Emergency Services

Emergency Care

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

Emergency Services are available from Plan Hospital Emergency Departments 24 hours a day, 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

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

To request prior authorization the Non-Plan Provider must call the notification telephone number on your Kaiser Permanente ID card before you receive the care. Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized since we do not cover Post-Stabilization Care or related transportation provided by Non–Plan Providers that has not been authorized. If you receive care from a Non–Plan Provider that we have not authorized, you may have to pay the full cost of that care.

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

Urgent Care

Inside your Home Region Service Area

If you think you may need Urgent Care, call the appropriate appointment or advice nurse telephone number at a Plan Facility.

Out-of-Area Urgent Care

If you need Urgent Care due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), we cover Medically Necessary Services to prevent serious deterioration of your (or your unborn child’s) health from a Non–Plan Provider if all of the following are true:
• You receive the Services from Non–Plan Providers while you are temporarily outside your Home Region's Service Area
• You reasonably believed that your (or your unborn child’s) health would seriously deteriorate if you delayed treatment until you returned to your Home Region's Service Area

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

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

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

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

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

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

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

**Getting a referral**

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

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

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

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

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

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

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

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

Utilization Management ("UM") is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at kp.org/UM or call our Member Service Contact Center to request a printed copy. Please refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section of your EOC for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.
Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals. This description is only a brief summary of the authorization procedure. For more information, please refer to the EOC or call our Member Service Contact Center at 1-800-464-4000 (TTY users call 711).

**Second opinions**

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

**Timely Access to Care**

**Standards for appointment availability**

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

- Urgent Care: within 48 hours
- Nonurgent Primary Care Visit or Non-Physician Specialist Visit: within 10 business days
- Physician Specialist Visit: within 15 business days

The standards for appointment availability do not apply to Preventive Services. Your Plan Provider may recommend a specific schedule for Preventive Services, depending on your needs. The standards also do not apply to periodic follow-up care for ongoing conditions or standing referrals to specialists.

**Timely access to telephone assistance**

- DMHC developed the following standards for answering telephone questions:
- For telephone advice about whether you need to get care and where to get care: within 30 minutes, 24 hours a day, 7 days a week.
- For general questions: within 10 minutes during normal business hours.

**Interpreter Services**

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

**How Plan Providers are paid**

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

**Your costs**

**Cost Share (deductibles, Copayments, and Coinsurance)**

When you receive covered Services, you must pay the Cost Share amount listed in the EOC. In most cases, your provider will ask you to make a payment toward your Cost Share at the time you receive Services. Keep in mind that this payment may cover only a portion of your total Cost Share for the covered Services you receive, and you will be billed for any additional amounts.
that are due. In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for any Cost Share amounts that are due. The following are examples of when you may get a bill:

- You receive non-preventive Services during a preventive visit
- You receive diagnostic Services during a treatment visit
- You receive treatment Services during a diagnostic visit
- You receive Services from a second provider during your visit
- A Plan Provider is not able to collect Cost Share at the time you receive Services

In some cases, a Non-Plan Provider may be involved in the provision of covered Services at a Plan Facility or a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the covered Services you receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

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

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call weekdays 7 a.m. to 7 p.m. 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). Please 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. Please refer to "Outpatient Prescription Drugs, Supplies, and Supplements" section of the EOC for Services that are subject to the Drug Deductible.

**Plan Deductible**

If your coverage includes a Plan Deductible, the deductible limits will be specified in Your Benefits (Disclosure Form Part One). If you have a Plan Deductible, you must pay Charges for Services subject to the Plan Deductible until you meet the Plan Deductible each Accumulation Period. The only payments that count toward a Plan Deductible are those you make for covered Services.
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. Please refer to the EOC for more information about which Services are subject to the Plan Deductible and an explanation of how the deductible works.

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

**Plan Out-of-Pocket Maximum**

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

**Payment of Premiums**

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

**Financial liability**

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may have to pay the cost of noncovered Services you obtain from Plan Providers or Non–Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for the covered Services you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. In some cases, you may be eligible to receive Services from a terminated provider in accord with applicable law.

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

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

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

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

- As soon as possible, obtain a claim form by:
  - calling our Member Service Contact Center toll free at 1-800-464-4000 or 1-800-390-3510 (TTY users call 711), or
  - through our website at kp.org
  - one of our representatives will be happy to assist you if you need help completing our claim form
- If you have paid for Services, you must send us our completed claim form for reimbursement. Please attach any bills and receipts from the Non–Plan Provider
- To request that a Non–Plan Provider be paid for Services, you must send us our completed claim form and include any bills from the Non–Plan Provider. If the Non–Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the
Non–Plan Provider for covered Services other than your Cost Share amount, please call our Member Service toll free at 1-800-390-3510 for assistance

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

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

**Termination of benefits**

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

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

- The contract between your group and Kaiser Permanente is terminated for any reason
- You are no longer eligible for group coverage
- You intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider (if you intentionally commit fraud, we may terminate your membership by sending written notice to the Subscriber; termination will be effective 30 days from the date we send the notice. If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future. We may also report criminal fraud and other illegal acts to the authorities for prosecution
- Your group fails to pay Premiums for your Family (or if your Family fails to pay Premiums for Cal-COBRA coverage for your Family)

Please refer to the EOC for more information.

**Continuation of membership**

**Continuation of group coverage**

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

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

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

**Individual Plan**

If you want to remain a Health Plan member when your group coverage ends, you can enroll in one of our plans for individuals and families. The premiums and coverage under our individual plan coverage are different from those under your group coverage.
If you want your individual plan coverage to be effective when your group coverage ends, you must submit your application within the special enrollment period for enrolling in an individual plan due to loss of other coverage. Otherwise, you will have to wait until the next annual open enrollment period.

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

**Getting assistance**

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

**Member Services**

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

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

You can reach Member Services in the following ways:

**Call**  
1-800-464-4000 (English and more than 150 languages using interpreter services)  
1-800-788-0616 (Spanish)  
1-800-757-7585 (Chinese dialects)  
TTY users call 711  
24 hours a day, seven days a week (except closed holidays)

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

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

**Website**  
kp.org

**Dispute resolution and binding arbitration**

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

Independent medical review is available if you believe that we improperly denied, modified, or delayed Services or payment of Services, and that either (1) our denial was based on a finding that the Services are not Medically Necessary, or (2) for life-threatening or seriously debilitating conditions, the requested treatment was denied as experimental or investigational. Also, if you should file a grievance and you later need help with it because your grievance is an emergency, it hasn't been resolved to your satisfaction, or it's unresolved after 30 days, you may call the California Department of Managed Health Care toll free at 1-888-HMO-2219 and a TDD line (1-877-688-9891) for the hearing and speech impaired for assistance.
Except for Small Claims Court cases and claims that cannot be subject to binding arbitration under governing law, any dispute between Members, their heirs, or associated parties (on the one hand) and Health Plan, its health care providers, or other associated parties (on the other hand) for alleged violation of any duty arising from your Health Plan membership, must be decided through binding arbitration. This includes claims for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration.

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

**Renewal provisions**

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

**Principal exclusions, limitations, and reductions of benefits**

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

- Care in a residential care facility except for Services covered under "Substance Use Disorder Treatment" and "Mental Health Services" in the EOC
- Care in an intermediate care facility, unless otherwise stated in the EOC
- Chiropractic Services, unless otherwise stated in the EOC
- Cosmetic Services, except for Services covered under "Reconstructive Surgery" and "Prosthetic and Orthotic Devices" in the EOC
- Custodial care, except for covered hospice care
- Dental and orthodontic Services and X-rays, except for Services covered under "Dental and Orthodontic Services" in the EOC
- Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies
- Experimental or investigational Services, except as required by law for certain clinical trials. You can request an independent medical review if you disagree with our decision to deny treatment because it is experimental or investigational (please refer to the EOC for details about independent medical review and other dispute resolution options)
- Hearing aids, unless otherwise stated in the EOC
- Items and services that are not health care items and services, unless otherwise stated in the EOC
- Items and services to correct refractive defects of the eye (such as eye surgery or contact lenses to reshape the eye)
- Massage therapy, unless otherwise stated in the EOC
- Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food, unless otherwise stated in the EOC
- Physical examinations related to employment, insurance, licensing, court orders, parole, or probation, unless a Plan Physician determines that the Services are Medically Necessary
- Routine foot care Services that are not Medically Necessary
• Services not approved by the federal Food and Drug Administration ("FDA") that by law require FDA approval in order to be sold in the U.S., except for certain experimental or investigational Services, and as required by law for certain clinical trials
• Services performed by unlicensed people, except for behavior health treatment covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the EOC
• Services related to conception, pregnancy, or delivery in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate
• Services related to a noncovered Service, except for Services we would otherwise cover to treat complications of the noncovered Service
• Travel and lodging expenses, unless otherwise stated in the EOC
• Treatment of hair loss or growth

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

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

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

To become a Member

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

If you are eligible to enroll, simply return a completed enrollment application to your group. Be sure to ask your group for your group (purchaser) number and the date when your coverage becomes effective.

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

Persons barred from enrolling
You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.
Miscellaneous Notices

Completion of Services from Non–Plan Providers

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

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

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

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends
- Serious Chronic Conditions. We may cover these Services until the earlier of (1) 12 months from your membership effective date if you are a new Member; (2) 12 months from the termination date of the terminated provider; or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - it persists without full cure
  - it worsens over an extended period of time
  - it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- 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's Service Area (the requirement that the provider agree to providing Services inside your home Region’s Service Area doesn’t apply if you were receiving covered Services from the provider outside the Service Area when the provider’s contract terminated)

• The Services to be provided to you would be covered Services under the EOC if provided by a Plan Provider

• You request completion of Services within 30 days (or as soon as reasonably possible) from your membership effective date if you are a new Member, or from the termination date of the Plan Provider

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

Drug formulary
The drug formulary includes a list of drugs that our Pharmacy and Therapeutics Committee has approved for our Members. Our Pharmacy and Therapeutics Committee, which is primarily composed of Plan Physicians and pharmacists, selects 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 our Member Service Contact Center. 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.

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

Privacy practices
Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information. Your protected health information is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information. You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give protected health information to others, such as government agencies or in judicial actions. In addition, protected health information is shared with employers only with your authorization or as otherwise permitted by law.

We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our Notice of Privacy Practices (see below). Giving us authorization is at your discretion.
This is only a brief summary of some of our key privacy practices. OUR NOTICE OF PRIVACY PRACTICES WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY PRACTICES AND YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION, IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. To request a copy, please call our Member Service Contact Center at 1-800-464-4000. You can also find the notice at your local Plan Facility or on our website at kp.org.

**Special note about Medicare**
The information contained in this booklet is not applicable to most Medicare beneficiaries. Please check with your group to determine the correct 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).

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

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

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

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

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

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

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

**Drug Deductible:** The amount you must pay 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.
Please 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 woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

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

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

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

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

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

**Family:** A Subscriber and all of 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.

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

**Medically Necessary:** A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.
Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

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

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

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your (or your unborn child’s) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:
- You are temporarily outside your Home Region's Service Area
- A reasonable person would have believed that your (or your unborn child’s) health would seriously deteriorate if you delayed treatment until you returned to your Home Region's Service Area

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

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

Plan Deductible: The amount you must pay 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, please refer to the EOC for a list of the Services that are subject to the Plan Deductible.

Plan Facility: Any facility listed in the enclosed facility listing or on our website at kp.org/facilities for your Home Region's Service Area. 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 our Member Service Contact Center at 1-800-464-4000 (TTY users call 711).

Plan Hospital: Any hospital listed in the enclosed facility listing or on our website at kp.org/facilities for your Home Region's Service Area. 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 our Member Service Contact Center at 1-800-464-4000 (TTY users call 711).

Plan Medical Office: Any medical office listed in the enclosed facility listing or on our website at kp.org/facilities for your Home Region's Service Area. 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 our Member Service Contact Center at 1-800-464-4000 (TTY users call 711).

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

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Please refer to the directory on our website at kp.org/facilities for your Home Region's 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 our Member Service Contact Center at 1-800-464-4000 (TTY users call 711).

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

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that Health Plan designates as a Plan Provider in your Home Region's Service Area.
**Post-Stabilization Care:** Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that this condition is Stabilized.

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

**Region:** A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 or each year and are currently the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Idaho, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at kp.org or call our Member Service Contact Center at 1-800-464-4000 (TTY users call 711).

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

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

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

- All ZIP codes in Alameda County are inside our Service Area: 94501–02, 94505, 94514, 94536–46, 94550–52, 94555, 94557, 94560, 94566, 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 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
- 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, 94576
- 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,

Disclosure Form July 31, 2020
Kaiser Foundation Health Plan, Inc.
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 Tulare County are inside our Service Area: 93238, 93261

• The following ZIP codes in Ventura County are inside our Service Area: 90265, 91304, 91307, 91311, 91319–20, 91358–62, 91377, 93001–07, 93009–12, 93015–16, 93020–22, 93030–36, 93040–44, 93060–66, 93094, 93099, 93252

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

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

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

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

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

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

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

Online tools designed to make your life easier

Once you join ...
Visit kp.org/newmember to get started. It’s easy to register at kp.org, choose your doctor, transfer your prescriptions, and schedule your first routine appointment. And if you need help, just give us a call.

Already a member?
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The right choice for a healthier you

Having a good health plan is important. So is getting quality care. With Kaiser Permanente, you get both.

Want to learn more?

Choosing a health plan is a big decision — so we’re here to help. Talk to an enrollment specialist today about specialty care, extra perks, and more. Call 1-800-324-9208 (TTY 711), Monday through Friday, 7 a.m. to 6 p.m. PT.

Current members with questions can call our Member Service Contact Center, 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)

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