KAISER PERMANENTE®

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

Disclosure Form for Kaiser Permanente for Individuals and Families Copayment Plans and Deductible Plans

Your Health Plan Coverage

Member Service Contact Center
24 hours a day, seven days a week
(except holidays, and after 5 p.m. the day after Thanksgiving, Christmas Eve, and New Year's Eve)
1-800-464-4000 toll free
1-800-777-1370 (toll free TTY for the hearing/speech impaired)
kp.org

60093034

Help in Your Language

Interpreters are available 24 hours a day, seven days a week, at no cost to you. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may be able to get materials written in your language. For more information, call our Member Service Contact Center at 1-800-464-4000 or 1-800-777-1370 (TTY) 24 hours a day, seven days a week (except holidays, and after 5 p.m. the day after Thanksgiving, Christmas Eve, and New Year's Eve).

Ayuda en su propio idioma

Tenemos disponibles intérpretes 24 horas al día, 7 días a la semana, sin ningún costo para usted. También podemos ofrecerle a usted, sus familiares y sus amigos cualquier tipo de ayuda que necesiten para tener acceso a nuestras instalaciones y servicios. Además, usted puede obtener materiales escritos en su idioma. Para más información, llame a nuestro Centro de Llamadas de Servicios a los Miembros al 1-800-788-0616 ó 1-800-777-1370 (TTY) los días de semana de 7 a.m. a 7 p.m., y los fines de semana de 7 a.m. a 3 p.m.

語言翻譯協助

提供　週七天，　天廿四小時翻譯。我們也向會員及其親友提供利用我處設施及服務所需之任何協助。此外會員還可索取以其母語編寫的資料。若需更多資訊，請於週一至週五上午七時至下午七時及週末上午七時至下午三時致電會員服務電話中心，電話號碼為 **1-800-757-7585** 或 **1-800-777-1370**（聽障專線）。

Health Plan Benefits and Coverage Matrix for the Copayment 25 Plan

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

The Services described below 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 Service Area, except where specifically noted to the contrary in the *Membership Agreement* (*Agreement*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	$2,500 per calendar year
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to this amount.	
Deductible	None
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$25 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations, exams, and treatment	$25 per visit
Physical, occupational, and speech therapy	$25 per visit

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$100 per procedure
Allergy injections (including allergy serum)	$5 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	$10 per encounter
Preventive X-rays, screenings, and laboratory tests as described in the *Agreement*	No charge
MRI, most CT, and PET scans	$50 per procedure
Health education:	
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$200 per day

Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit
Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).	

Ambulance Services	**You Pay**
Ambulance Services	$100 per trip

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, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply
Most generic refills through our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply

Most brand-name items at a Plan Pharmacy	$35 for up to a 30-day supply, $70 for a 31- to 60-day supply, or $105 for a 61- to 100-day supply
Most brand-name refills through our mail-order service	$35 for up to a 30-day supply or $70 for a 31- to 100-day supply

Durable Medical Equipment	**You Pay**
The durable medical equipment for home use listed in the *Agreement* in accord with our durable medical equipment formulary guidelines (most durable medical equipment is **not covered**)	20% Coinsurance

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization (up to 30 days per calendar year)	$200 per day
Outpatient mental health evaluation and treatment:	
Up to a total of 20 individual and group visits per calendar year that include Services for mental health evaluation or treatment	$25 per individual visit $12 per group visit
Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	$12 per visit
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the *Agreement*.	

Chemical Dependency Services	**You Pay**
Inpatient detoxification	$200 per day
Individual outpatient chemical dependency evaluation and treatment	$25 per visit
Group outpatient chemical dependency treatment	$5 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission

Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge

Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the *Agreement* (most external prosthetic and orthotic devices are **not covered**)	No charge
Hospice care	No charge

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

Health Plan Benefits and Coverage Matrix for the Copayment 40 Plan

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

The Services described below 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 Service Area, except where specifically noted to the contrary in *the Membership Agreement* (*Agreement*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	$3,000 per calendar year
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to this amount.	
Deductible	None
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$40 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations, exams, and treatment	$40 per visit
Physical, occupational, and speech therapy	$40 per visit

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$200 per procedure
Allergy injections (including allergy serum)	$5 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	$10 per encounter
Preventive X-rays, screenings, and laboratory tests as described in the *Agreement*	No charge
MRI, most CT, and PET scans	$50 per procedure
Health education:	
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$350 per day

Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit
Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).	

Ambulance Services	**You Pay**
Ambulance Services	$200 per trip

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, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply
Most generic refills through our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply

Most brand-name items at a Plan Pharmacy	$35 for up to a 30-day supply, $70 for a 31- to 60-day supply, or $105 for a 61- to 100-day supply
Most brand-name refills through our mail-order service	$35 for up to a 30-day supply or $70 for a 31- to 100-day supply

Durable Medical Equipment	**You Pay**
The durable medical equipment for home use listed in the *Agreement* in accord with our durable medical equipment formulary guidelines (most durable medical equipment is **not covered**)	50% Coinsurance

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization (up to 30 days per calendar year)	$350 per day
Outpatient mental health evaluation and treatment:	
Up to a total of 20 individual and group visits per calendar year that include Services for mental health evaluation or treatment	$40 per individual visit $20 per group visit
Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	$20 per visit
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the *Agreement*.	

Chemical Dependency Services	**You Pay**
Inpatient detoxification	$350 per day
Individual outpatient chemical dependency evaluation and treatment	$40 per visit
Group outpatient chemical dependency treatment	$5 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission

Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge

Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
‹ternal prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the *Agreement* (most external prosthetic and orthotic devices are **not covered**)	No charge
Hospice care	No charge

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

Health Plan Benefits and Coverage Matrix for the Copayment 50 Plan

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

The Services described below 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 Service Area, except where specifically noted to the contrary in the *Membership Agreement* (*Agreement)* for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	$3,500 per calendar year
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to this amount	
Deductible	None
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$50 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations, exams, and treatment	$50 per visit
Physical, occupational, and speech therapy	$50 per visit

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$250 per procedure
Allergy injections (including allergy serum)	$5 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	$10 per encounter
Preventive X-rays, screenings, and laboratory tests as described in the *Agreement*	No charge
MRI, most CT, and PET scans	$50 per procedure
Health education:	
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$500 per day

Emergency Health Coverage	**You Pay**
Emergency Department visits	$150 per visit
Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).	

Ambulance Services	**You Pay**
Ambulance Services	$300 per trip

Prescription Drug Coverage	**You Pay**
The outpatient prescription drugs listed in the *Agreement* in accord with our drug formulary guidelines at Plan Pharmacies or through our mail-order service (most outpatient prescription drugs are **not covered**):	
Generic items	$10 for up to a 100-day supply
Brand-name items	$35 for up to a 100-day supply

Durable Medical Equipment	You Pay
The durable medical equipment for home use listed in the *Agreement* in accord with our durable medical equipment formulary guidelines (most durable medical equipment is **not covered**)	50% Coinsurance
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization (up to 30 days per calendar year)	$500 per day
Outpatient mental health evaluation and treatment:	
Up to a total of 20 individual and group visits per calendar year that include Services for mental health evaluation or treatment	$50 per individual visit $25 per group visit
Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	$25 per visit
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the *Agreement*.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	$500 per day
Individual outpatient chemical dependency evaluation and treatment	$50 per visit
Group outpatient chemical dependency treatment	$5 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the *Agreement* (most external prosthetic and orthotic devices are **not covered**)	No charge
Hospice care	No charge

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

Health Plan Benefits and Coverage Matrix for the Deductible 20/500 plan

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

The Services described below 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 Service Area, except where specifically noted to the contrary in the *Membership Agreement* (*Agreement*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	$2,500 per calendar year
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services, plus all your Deductible payments, add up to this amount.	
Deductible for Certain Services	$500 per calendar year
For Services subject to the Deductible, you must pay Charges for Services you receive in a calendar year until you reach the Deductible amount.	
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$20 per visit (Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Deductible doesn't apply)
Family planning counseling and consultations	No charge (Deductible doesn't apply)
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge (Deductible doesn't apply)
Eye exams for refraction	No charge (Deductible doesn't apply)
Hearing exams	No charge (Deductible doesn't apply)
Urgent care consultations, exams, and treatment	$20 per visit (Deductible doesn't apply)
Physical, occupational, and speech therapy	$20 per visit after Deductible
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$50 per procedure after Deductible
Allergy injections (including allergy serum)	$5 per visit after Deductible
Most immunizations (including the vaccine)	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *Agreement*	No charge (Deductible doesn't apply)
Health education:	
Covered individual health education counseling	No charge (Deductible doesn't apply)
Covered health education programs	No charge (Deductible doesn't apply)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$100 per day after Deductible
Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit after Deductible
Note: After you meet the Deductible, this Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).	
Ambulance Services	**You Pay**
Ambulance Services	$150 per trip after Deductible

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, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply (Deductible doesn't apply)
Most generic refills through our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply (Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$35 for up to a 30-day supply, $70 for a 31- to 60-day supply, or $105 for a 61- to 100-day supply (Deductible doesn't apply)
Most brand-name refills through our mail-order service	$35 for up to a 30-day supply or $70 for a 31- to 100-day supply (Deductible doesn't apply)
Durable Medical Equipment	**You Pay**
Most covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines up to a $2,000 calendar-year benefit limit as described in the *Agreement*	20% Coinsurance (Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization (up to 30 days per calendar year)	$100 per day after Deductible
Outpatient mental health evaluation and treatment:	
Up to a total of 20 individual and group visits per calendar year that include Services for mental health evaluation or treatment	$20 per individual visit (Deductible doesn't apply) $10 per group visit (Deductible doesn't apply)
Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	$10 per visit (Deductible doesn't apply)
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the *Agreement*.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	$100 per day after Deductible
Individual outpatient chemical dependency evaluation and treatment	$20 per visit (Deductible doesn't apply)
Group outpatient chemical dependency treatment	$5 per visit (Deductible doesn't apply)
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission after Deductible
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge (Deductible doesn't apply)
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge after Deductible
Covered external prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge (Deductible doesn’tapply)
Hospice care	No charge (Deductible doesn't apply)

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

Health Plan Benefits and Coverage Matrix for the Deductible 25/1000 plan

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

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Annual Out-of-Pocket Maximum for Certain Services	$3,000 per calendar year
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services, plus all your Deductible payments, add up to this amount.	
Deductible for Certain Services	$1,000 per calendar year
For Services subject to the Deductible, you must pay Charges for Services you receive in a calendar year until you reach the Deductible amount.	
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$25 per visit (Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Deductible doesn't apply)
Family planning counseling and consultations	No charge (Deductible doesn't apply)
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge (Deductible doesn't apply)
Eye exams for refraction	No charge (Deductible doesn't apply)
Hearing exams	No charge (Deductible doesn't apply)
Urgent care consultations, exams, and treatment	$25 per visit (Deductible doesn't apply)
Physical, occupational, and speech therapy	$25 per visit after Deductible

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$150 per procedure after Deductible
Allergy injections (including allergy serum)	$5 per visit after Deductible
Most immunizations (including the vaccine)	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *Agreement*	No charge (Deductible doesn't apply)
MRI, most CT, and PET scans	$50 per procedure after Deductible
Health education:	
Covered individual health education counseling	No charge (Deductible doesn't apply)
Covered health education programs	No charge (Deductible doesn't apply)

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$250 per day after Deductible

Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit after Deductible
Note: After you meet the Deductible, this Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).	

Ambulance Services	**You Pay**
Ambulance Services	$150 per trip after Deductible

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, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply (Deductible doesn't apply)
Most generic refills through our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply (Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$35 for up to a 30-day supply, $70 for a 31- to 60-day supply, or $105 for a 61- to 100-day supply (Deductible doesn't apply)
Most brand-name refills through our mail-order service	$35 for up to a 30-day supply or $70 for a 31- to 100-day supply (Deductible doesn't apply)
Durable Medical Equipment	**You Pay**
The durable medical equipment for home use listed in the *Agreement* in accord with our durable medical equipment formulary guidelines (most durable medical equipment is **not covered**)	20% Coinsurance (Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization (up to 30 days per calendar year)	$250 per day after Deductible
Outpatient mental health evaluation and treatment:	
Up to a total of 20 individual and group visits per calendar year that include Services for mental health evaluation or treatment	$25 per individual visit (Deductible doesn't apply) $12 per group visit (Deductible doesn't apply)
Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	$12 per visit (Deductible doesn't apply)
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the *Agreement*.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	$250 per day after Deductible
Individual outpatient chemical dependency evaluation and treatment	$25 per visit (Deductible doesn't apply)
Group outpatient chemical dependency treatment	$5 per visit (Deductible doesn't apply)
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission after Deductible
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge (Deductible doesn't apply)
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge after Deductible
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the *Agreement* (most external prosthetic and orthotic devices are **not covered**)	No charge (Deductible doesn't apply)
Hospice care	No charge (Deductible doesn't apply)

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

Health Plan Benefits and Coverage Matrix for the Deductible 30/1500 plan

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- 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 Service Area, except where specifically noted to the contrary in the *Membership Agreement* (*Agreement*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	$3,500 per calendar year
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services, plus all your Deductible payments, add up to one this amount.	
Deductible for Certain Services	$1,500 per calendar year
For Services subject to the Deductible, you must pay Charges for Services you receive in a calendar year until you reach the Deductible amount.	
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$30 per visit (Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Deductible doesn't apply)
Family planning counseling and consultations	No charge (Deductible doesn't apply)
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge (Deductible doesn't apply)
Eye exams for refraction	No charge (Deductible doesn't apply)
Hearing exams	No charge (Deductible doesn't apply)
Urgent care consultations, exams, and treatment	$30 per visit (Deductible doesn't apply)
Physical, occupational, and speech therapy	$30 per visit after Deductible

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$250 per procedure after Deductible
Allergy injections (including allergy serum)	$5 per visit after Deductible
Most immunizations (including the vaccine)	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *Agreement*	No charge (Deductible doesn't apply)
MRI, most CT, and PET scans	$50 per procedure after Deductible
Health education:	
Covered individual health education counseling	No charge (Deductible doesn't apply)
Covered health education programs	No charge (Deductible doesn't apply)

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$500 per day after Deductible

Emergency Health Coverage	**You Pay**
Emergency Department visits	$150 per visit after Deductible
Note: After you meet the Deductible, this Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).	

Ambulance Services	**You Pay**
Ambulance Services	$150 per trip after Deductible

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, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply (Deductible doesn't apply)
Most generic refills through our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply (Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$35 for up to a 30-day supply, $70 for a 31- to 60-day supply, or $105 for a 61- to 100-day supply (Deductible doesn't apply)
Most brand-name refills through our mail-order service	$35 for up to a 30-day supply or $70 for a 31- to 100-day supply (Deductible doesn't apply)

Durable Medical Equipment	You Pay
The durable medical equipment for home use listed in the *Agreement* in accord with our durable medical equipment formulary guidelines (most durable medical equipment is **not covered**)	30% Coinsurance (Deductible doesn't apply)

Mental Health Services	You Pay
Inpatient psychiatric hospitalization (up to 10 days per calendar year)	$500 per day after Deductible
Outpatient mental health evaluation and treatment:	
Up to a total of 10 individual and group visits per calendar year that include Services for mental health evaluation or treatment	$30 per individual visit (Deductible doesn't apply) $15 per group visit (Deductible doesn't apply)
Up to 30 additional group visits in the same calendar year that meet Medical Group criteria	$15 per visit (Deductible doesn't apply)
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the *Agreement*.	

Chemical Dependency Services	You Pay
Inpatient detoxification	$500 per day after Deductible
Individual outpatient chemical dependency evaluation and treatment	$30 per visit (Deductible doesn't apply)
Group outpatient chemical dependency treatment	$5 per visit (Deductible doesn't apply)
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission after Deductible

Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge (Deductible doesn't apply)

Chiropractic Services	You Pay
Chiropractic office visits (up to a total of 20 visits per calendar year)	$15 (Deductible doesn't apply)
X-rays and lab tests that are covered Chiropractic Services	No charge
Chiropractic appliances	$50 Allowance per calendar year

Other	You Pay
Skilled nursing facility care (up to 60 days per benefit period)	$50 per day after Deductible
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the *Agreement* (most external prosthetic and orthotic devices are **not covered**)	No charge (Deductible doesn't apply)
Hospice care	No charge (Deductible doesn't apply)

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

Health Plan Benefits and Coverage Matrix for the Deductible 40/2000 plan

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

The Services described below 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 Service Area, except where specifically noted to the contrary in the *Membership Agreement* (*Agreement*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	$4,000 per calendar year
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services, plus all your Deductible payments, add up to this amount.	
Deductible for Certain Services	$2,000 per calendar year
For Services subject to the Deductible, you must pay Charges for Services you receive in a calendar year until you reach the Deductible amoun.:	
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$40 per visit (Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Deductible doesn't apply)
Family planning counseling and consultations	No charge (Deductible doesn't apply)
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge (Deductible doesn't apply)
Eye exams for refraction	No charge (Deductible doesn't apply)
Hearing exams	No charge (Deductible doesn't apply)
Urgent care consultations, exams, and treatment	$40 per visit (Deductible doesn't apply)
Physical, occupational, and speech therapy	$40 per visit after Deductible

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$250 per procedure after Deductible
Allergy injections (including allergy serum)	$5 per visit after Deductible
Most immunizations (including the vaccine)	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *Agreement*	No charge (Deductible doesn't apply)
MRI, most CT, and PET scans	$50 per procedure after Deductible
Health education:	
Covered individual health education counseling	No charge (Deductible doesn't apply)
Covered health education programs	No charge (Deductible doesn't apply)

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$500 per day after Deductible

Emergency Health Coverage	**You Pay**
Emergency Department visits	$150 per visit after Deductible
Note: After you meet the Deductible, this Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).	

Ambulance Services	**You Pay**
Ambulance Services	$150 per trip after Deductible

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, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply (Deductible doesn't apply)
Most generic refills through our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply (Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$35 for up to a 30-day supply, $70 for a 31- to 60-day supply, or $105 for a 61- to 100-day supply (Deductible doesn't apply)
Most brand-name refills through our mail-order service	$35 for up to a 30-day supply or $70 for a 31- to 100-day supply (Deductible doesn't apply)

Durable Medical Equipment	You Pay
The durable medical equipment for home use listed in the *Agreement* in accord with our durable medical equipment formulary guidelines (most durable medical equipment is **not covered**)	30% Coinsurance (Deductible doesn't apply)

Mental Health Services	You Pay
Inpatient psychiatric hospitalization (up to 10 days per calendar year)	$500 per day after Deductible
Outpatient mental health evaluation and treatment:	
Up to a total of 10 individual and group visits per calendar year that include Services for mental health evaluation or treatment	$40 per individual visit (Deductible doesn't apply) $20 per group visit (Deductible doesn't apply)
Up to 30 additional group visits in the same calendar year that meet Medical Group criteria	$20 per visit (Deductible doesn't apply)
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the *Agreement*.	

Chemical Dependency Services	You Pay
Inpatient detoxification	$500 per day after Deductible
Individual outpatient chemical dependency evaluation and treatment	$40 per visit (Deductible doesn't apply)
Group outpatient chemical dependency treatment	$5 per visit (Deductible doesn't apply)
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission after Deductible

Home Health Services	You Pay
Home health care (up to 100 visits per calendar year)	No charge (Deductible doesn't apply)

Other	You Pay
Skilled nursing facility care (up to 60 days per benefit period)	$50 per day after Deductible
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the *Agreement* (most external prosthetic and orthotic devices are **not covered**)	No charge (Deductible doesn't apply)
Hospice care	No charge (Deductible doesn't apply)

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

Health Plan Benefits and Coverage Matrix for the Deductible 40/3000 plan

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

The Services described below 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 Service Area, except where specifically noted to the contrary in the *Membership Agreement* (*Agreement*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Annual Out-of-Pocket Maximum for Certain Services	$6,000 per calendar year
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services, plus all your Deductible payments (except prescription drugs), add up to this amount.	
Deductible for Certain Services	$3,000 per calendar year
For Services subject to the Deductible, you must pay Charges for Services you receive in a calendar year until you reach the Deductible amount.	
Deductible for Certain Drugs	$250 per Member per calendar year
Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$40 per visit (Deductible doesn't apply)
Routine physical maintenance exams, including well-woman exams	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Deductible doesn't apply)
Family planning counseling and consultations	No charge (Deductible doesn't apply)
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge (Deductible doesn't apply)
Eye exams for refraction	No charge (Deductible doesn't apply)
Hearing exams	No charge (Deductible doesn't apply)
Urgent care consultations, exams, and treatment	$40 per visit (Deductible doesn't apply)
Physical, occupational, and speech therapy	$40 per visit after Deductible
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	20% Coinsurance after Deductible
Allergy injections (including allergy serum)	$5 per visit after Deductible
Most immunizations (including the vaccine)	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *Agreement*	No charge (Deductible doesn't apply)
MRI, most CT, and PET scans	$150 per procedure after Deductible
Health education:	
Covered individual health education counseling	No charge (Deductible doesn't apply)
Covered health education programs	No charge (Deductible doesn't apply)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	20% Coinsurance after Deductible
Emergency Health Coverage	**You Pay**
Emergency Department visits	$200 per visit after Deductible
Note: After you meet the Deductible, this Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).	
Ambulance Services	**You Pay**
Ambulance Services	$150 per trip after Deductible

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, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply (Deductible doesn't apply)
Most generic refills through our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply (Deductible doesn't apply)
Most brand-name items at a Plan Pharmacy	$35 for up to a 30-day supply, $70 for a 31- to 60-day supply, or $105 for a 61- to 100-day supply after $250 Deductible for certain drugs
Most brand-name refills through our mail-order service	$35 for up to a 30-day supply or $70 for a 31- to 100-day supply after $250 Deductible for certain drugs
Durable Medical Equipment	**You Pay**
The durable medical equipment for home use listed in the *Agreement* in accord with our durable medical equipment formulary guidelines (most durable medical equipment is **not covered**)	30% Coinsurance (Deductible doesn't apply)
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization (up to 30 days per calendar year)	20% Coinsurance after Deductible
Outpatient mental health evaluation and treatment:	
Up to a total of 20 individual and group visits per calendar year that include Services for mental health evaluation or treatment	$40 per individual visit (Deductible doesn't apply) $20 per group visit (Deductible doesn't apply)
Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	$20 per visit (Deductible doesn't apply)
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the *Agreement*.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	20% Coinsurance after Deductible
Individual outpatient chemical dependency evaluation and treatment	$40 per visit (Deductible doesn't apply)
Group outpatient chemical dependency treatment	$5 per visit (Deductible doesn't apply)
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission after Deductible
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge (Deductible doesn't apply)
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	20% Coinsurance after Deductible
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the *Agreement* (most external prosthetic and orthotic devices are **not covered**)	No charge (Deductible doesn't apply)
Hospice care	No charge (Deductible doesn't apply)

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

Introduction

Welcome to Kaiser Permanente

When you join Kaiser Permanente, you get a health plan that's dedicated to your total well-being.

Our health education programs offer you great ways to protect and improve your health. You get a wealth of information online with kp.org. Save time in requesting routine appointments and prescription refills. Use the extensive health and drug encyclopedias to learn more about your health. Find Plan Facilities and providers close to home or work.

When you need medical care, we've got you covered. You can have a personal physician who understands your lifestyle. You can often take care of many health needs at one place, in one trip—from office consultations, exams, and treatment to laboratory tests, pharmacy, and X-rays. Most of our facilities provide same-day Urgent Care appointments, and many have evening and weekend appointments. And, you're not limited to receiving care from just one facility; you pick the Plan Facility that's most convenient for you. If you need specialty care, you have access to a wide array of medical specialties. You can even self-refer to selected specialties. And you can depend on the security of emergency coverage anywhere in the world.

We are committed to investing first and foremost in your health. From routine checkups to online services to Emergency Services, you can count on us to help you stay healthy.

About this booklet

This *Disclosure Form* summarizes some of the important features of your Kaiser Permanente membership, as well as general exclusions and limitations of your coverage. ***Please read the following information so that you will know from whom or what group of providers you may obtain health care. Also, you should read this*** **Disclosure Form** ***and the*** **Membership Agreement and Evidence of Coverage** ***carefully if you have special health care needs*****.**

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." Your Home Region is the Service Area where you are enrolled. This *Disclosure Form* describes your coverage in your Home Region. Also, this *Disclosure Form* describes different benefit plans, for example benefit plans that include Deductibles for specified Services. Everything in this section of the *Disclosure Form* applies to all benefit plans, except as otherwise indicated. Please see the Health Plan Benefits and Coverage Matrix for a summary of Deductibles, Copayments, and Coinsurance. If you have questions about benefits, please call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**) or refer to the *Membership Agreement and Evidence of Coverage*

Some capitalized terms have special meaning in this *Disclosure Form,* as described in the "Definitions" section at the end of this booklet. Once you become a Kaiser Permanente member, we will send you a *Membership Agreement and Evidence of Coverage* with your acceptance notice. Your *Membership Agreement and Evidence of Coverage* provides details about the terms and conditions of your coverage. This *Disclosure Form* is only a summary. A *Membership Agreement and Evidence of Coverage* is available by calling our Member Service Contact Center toll free at **1-800-464-4000** if you would like to review one before being accepted for membership.

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 toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**), 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 care

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 *Membership Agreement and Evidence of Coverage* for the following Services listed below:

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

For Plan Facility locations, please refer to the enclosed facility listing, *Your Guidebook to Kaiser Permanente Services (Your Guidebook),* our Web site at **kp.org**, or your local telephone book under "Kaiser Permanente."

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.

Post-Stabilization Care. Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that this condition is Stabilized. We cover Post-Stabilization Care from a Non–Plan Provider, including inpatient care at a Non–Plan Hospital, only if we provide prior authorization for the care (prior authorization means that we must approve the Services in advance).

To request authorization to receive Post-Stabilization Care from a Non–Plan Provider, you must call us toll free at **1-800-225-8883** (TTY users call **711**) or the notification telephone number on your Kaiser Permanente ID card *before* you receive the care if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible). Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized since we do not cover unauthorized Post-Stabilization Care or related transportation provided by Non–Plan Providers.

Please refer to the *Membership Agreement and Evidence of Coverage* for coverage information, exclusions, and limitations.

Urgent Care

Inside your Home Region Service Area. If you think you may need Urgent Care, all the appropriate appointment or advice nurse telephone number at a Plan Facility. Please refer to *Your Guidebook* for advice nurse and Plan Facility telephone numbers.

Out-of Area urgent Care. If you have an Urgent Care need 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
- 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

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

Your ID card

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

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

If you need to get care before you receive your ID card, but after you have received your acceptance notice, when you make an appointment or get covered care, simply say that you are a new individual plan Member and give your medical record number and the effective date of coverage, both of which are on the acceptance notice.

Interpreter Services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services are available 24 hours a day, seven days a week, at no cost to you. For more information about the interpreter services we offer, please call our Member Service Contact Center.

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 facility locations, please refer to the enclosed facility listing or call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**).

- 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* for Emergency Department locations in your area)
- Same-day Urgent Care appointments are available at many locations (please refer to *Your Guidebook* 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* for locations in your area)

Plan Medical Offices and Plan Hospitals for your area are listed in *Your Guidebook. 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 periodically updated. We will mail you *Your Guidebook* after you've enrolled. If you do not receive a copy or need another copy, call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**, 24 hours a day, seven days a week (except holidays, and after 5 p.m. the day after Thanksgiving, Christmas Eve, and New Year's Eve). You can also download a copy from our Web site at **kp.org**.

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 for any reason. To learn how to select a personal Plan Physician, please call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**). You can find a directory of our Plan Physicians on our Web site at **kp.org**. For the current list of physicians who are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook*.

Getting a referral

Referrals to Plan Providers

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

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

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

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

Medical Group authorization procedure for certain referrals

The following 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.** If your Plan Physician prescribes durable medical equipment, he or she will submit a written referral to the Plan Hospital's durable medical equipment coordinator, who will authorize the durable medical equipment if he or she determines that your durable medical equipment coverage includes the item and that the item is listed on our formulary for your condition. If the item doesn't appear to meet our durable medical equipment formulary guidelines, then the durable medical equipment coordinator will contact the Plan Physician for additional information. If the durable medical equipment request still doesn't appear to meet our durable medical equipment formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our durable medical equipment formulary, please refer to the *Membership Agreement and Evidence of Coverage*
- **Ostomy and urological supplies.** If your Plan Physician prescribes ostomy or urological supplies, he or she will submit a written referral to the Plan Hospital's designated coordinator, who will authorize the item if he or she determines that it is covered and the item is listed on our soft goods formulary for your condition. If the item doesn't appear to meet our soft goods formulary guidelines, then the coordinator will contact the Plan Physician for additional information. If the request still doesn't appear to meet our soft goods formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our soft goods formulary, please refer to the *Membership Agreement and Evidence of Coverage*
- **Services not available from Plan Providers.** If your Plan Physician decides that you require covered Services not available from Plan Providers, he or she will recommend to the Medical Group that you be referred to a Non–Plan Provider inside or outside your Home Region's Service Area. The appropriate Medical Group designee will authorize the Services if he or she determines that they are Medically Necessary and are not available from a Plan Provider. Referrals to Non–Plan Physicians will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your Plan Physician what Services have been authorized
- **Transplants.** If your Plan Physician makes a written referral for a transplant, the Medical Group's regional transplant advisory committee or board (if one exists) will authorize the Services if it determines that they are Medically Necessary. In cases where no transplant committee or board exists, the Medical Group will refer you to physician(s) at a transplant center, and the Medical Group will authorize the Services if the transplant center's physician(s) determine that they are Medically Necessary. Note: A Plan Physician may provide or authorize a corneal transplant without using this Medical Group transplant authorization procedure

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 and other Services that are subject to an authorization procedure, please refer to the *Membership Agreement and Evidence of Coverage* or call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**).

Second opinions

If you want a second opinion, you can either ask your personal Plan Physician to help you arrange for one, or you can make an appointment with another Plan Physician who is an appropriately qualified medical professional for your condition. For more information, please refer to the *Membership Agreement and Evidence of Coverage*.

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 ask your Plan Physician or call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**).

Your costs

Cost Sharing (Deductibles, Copayments, and Coinsurance)

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

- You receive Services during your visit that were not scheduled when you made your payment at check in
- You receive Services from a second provider during your visit that were not scheduled when you made your payment at check in
- You go in for Preventive Care Services and receive non-preventive Services during your visit that were not scheduled when you made your payment at check in
- You go in for Preventive Care Services and receive non-preventive Services during your visit that were not scheduled when you made your payment at check in
- You go in for Preventive Care Services and instead receive non-preventive Services during your visit
- At check-in, you ask to be billed for some or all of the Cost Sharing for the Services you will receive, and we agree to bill you
- Medical Group authorizes a referral to a Non-Plan Provider and the provider does not collect Cost Sharing a the time you receive Services

If you have questions about Cost Sharing for specific Services that you are scheduled to receive or that your provider orders during a visit or procedure, please visit our website at **kp.org/memberestimates** to use our Cost Sharing estimate tool or call our Member Service Contact Center weekdays 7 a.m. to 5 p.m. toll free at 1-800-390-3507 (TTY users call 1-800-777-1370).

Copayments and Coinsurance

A summary of Copayments and Coinsurance is listed in *the Health Plan Benefits and Coverage Matrix*. Please refer to the "Benefits and Cost Sharing" section of the *Membership Agreement and Evidence of Coverage* for the complete list of Copayments and Coinsurance.

Deductibles

If your coverage includes Deductibles, you must pay Charges for Services subject to the Deductible until you meet the Deductible each calendar year. The only payments that count toward a Deductible are those you make for covered Services that are subject to the Deductible.

After you meet the Deductible and for the remainder of that calendar year, you pay the applicable Copayment or Coinsurance, subject to the annual out-of-pocket maximum

A summary of which Services are subject to the Deductible is listed in *the Health Plan Benefits and Coverage Matrix*.When the Copayment or Coinsurance for a particular Service is described as "after Deductible," and you have not met the Deductible, you must pay Charges for those Services. Please refer to the "Benefits and Cost Sharing" section of the *Membership Agreement and Evidence of Coverage* for the complete list of the Services that are subject to the Deductible.

If you would like an estimate of the Charges for a Service before you schedule an appointment or procedure, please visit our website at **kp.org/memberestimates** to use our Cost Sharing estimate tool or call our Member Service Contact Center weekdays 7 a.m. to 5 p.m. toll free at **1-800-390-3507** (TTY users call **1-800-777-1370**).

When you pay Charges for Services subject to the Deductible, we will give you a receipt and we will send you a Summary of Accumulation. The Summary of Accumulation will include the total amounts you have paid toward your Deductible and toward your annual out-of-pocket maximum. You can also obtain a copy of this Summary of Accumulation from our Member Service Contact Center toll free at **1-800-390-3507**.

Please refer to *the Health Plan Benefits and Coverage Matrix* to learn if your coverage is subject to a Deductible and the amount of the Deductible. Please refer to the *Membership Agreement and Evidence of Coverage* for more information about Deductibles.

Annual out-of-pocket maximum

For Services that are subject to the annual out-of-pocket maximums, there is a limit to the total amount of Cost Sharing you must pay in a calendar year for Services you receive in the same calendar year. The limit amounts are specified in *the Health Plan Benefits and Coverage Matrix.* Please refer to the *Membership Agreement and Evidence of Coverage* for more information about annual out-of-pocket maximums. When Services are not subject to the annual out-of-pocket maximum, you must pay Copayments or Coinsurance even if you have already reached your annual out-of-pocket maximum. Please refer to the *Membership Agreement and Evidence of Coverage* for a list of Services that are subject to the annual out-of-pocket maximum.

If you are enrolled in a Deductible Plan, when you pay Cost Sharing that applies to the annual out-of-pocket maximum, we will give you a receipt and we will send you a Summary of Accumulation. The Summary of Accumulation will include the total amounts you have paid toward your Deductible and toward your annual out-of-pocket maximum. If you are not enrolled in a Deductible Plan, ask for and keep the receipt when you pay for one of the Services listed in the *Membership Agreement and Evidence of Coverage* that count toward the annual out-of-pocket maximum. When the receipts add up to the annual out-of-pocket maximum, please call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**) to find out where to turn in your receipts. When you turn them in, we will give you a document stating that you do not have to pay any more Cost Sharing for the specified Services through the end of the calendar year.

Payment of Premiums

Only Members for whom we have received the appropriate Premiums are entitled to coverage, and then only for the period for which we have received payment. You must prepay Premiums listed on the enclosed rate chart, applicable to your coverage, for each month on or before the last day of the preceding month. Your Premiums may change if you move to a new rate area.

Surcharge on Premiums for children under age 19. Premiums for the child will be subject to a 20% surcharge for a period of 12 months if both of the following are true on the date the person requesting the child's enrollment signed the child's application:

- The child did not have health care coverage for the previous 90 days
- Enrollment was not requested within 63 days of one of the following events:
  - the child is born, adopted, or placed for adoption
  - the child becomes a resident of California during the month that is not their birth month
  - the date a court order required someone to provide health care coverage for the child

When Premiums for the child are subject to this surcharge, the Premiums listed on the Rate Sheet applicable to the child's coverage will include the surcharge. At the end of that 12-month period, the surcharge will be automatically discontinued.

Financial liability

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for 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 covered care 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 "Termination of a Plan Provider's contract" 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, Out-of-Area Urgent Care from a Non–Plan Provider, or if you receive emergency ambulance Services, you must pay for the Services unless the provider agrees to bill us. If you want us to pay for the Services you must file a claim. We will reduce any payment we make to you or the Non–Plan Provider by applicable Cost Sharing.

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

- As soon as possible, request our claim form by calling our Member Service Contact Center toll free at **1-800-464-4000** or **1-800-390-3510** (TTY users call **1-800-777-1370**). 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 Sharing 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 *Membership Agreement and Evidence of Coverage* for additional instructions, coverage information, exclusions, limitations, and dispute resolution for denied claims.

Termination of benefits

You may terminate your membership by sending written notice, signed by the Subscriber, to the address below. Your membership will terminate at 11:59 p.m. on the last day of the month in which we receive your notice. Also, you must include with your notice all amounts payable related to the *Membership Agreement and Evidence of Coverage*, including Premiums, for the period prior to your termination date.

For Northern California Region Members:
Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 23059
San Diego, CA 92193-3059

For Southern California Region Members:
Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 23127
San Diego, CA 92193-3127

After your membership terminates, you will be billed as a non-Member for any Services you receive.

Membership will cease for the Subscriber if:

- The *Membership Agreement and Evidence of Coverage* between you and Health Plan is terminated for any reason
- You are no longer eligible for coverage as described in the *Membership Agreement and Evidence of Coverage*
- You intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider. We may terminate your membership immediately by sending written notice to the Subscriber. Termination will be effective on the date we send the notice and you will not be allowed to enroll in Health Plan in the future
- You fail to pay us the appropriate Premiums for your Family. If we terminate your membership because we did not receive the required Premiums when due, your coverage will continue during a 30 day grace period, but upon termination you will be responsible for paying all past due Premiums, including the Premiums for this grace period. Persons terminated for nonpayment may not enroll in Health Plan even after paying all amounts owed unless we approve the enrollment. Also, you must undergo a medical review unless we reinstate your membership without a lapse in coverage

Rescission of membership

In order for us to accept you for enrollment, you must meet eligibility requirements and undergo a medical review of the health history information you provided in your Health Coverage Application, including information provided during the enrollment process. Our decision to accept you (or any other applicant on this application) for coverage will be made only after we have thoroughly reviewed the health history information pertaining to you (and any other applicants) disclosed in the health coverage Application. Our review will include our reasonable efforts to verify the accuracy and completeness of the health history information disclosed in the Health Coverage Application. The process of review and verification of applicant health history information is called medical review and we are under a duty to complete it.

If we approved your application for membership without properly completing medical review, we may only rescind your membership if we can support a claim that you or someone on your behalf willfully misrepresented your health history information disclosed in the Health Coverage Application.

If we find a material inconsistency between your actual health status on the date your were accepted for enrollment and the information provided in your Health Coverage Application, we will notify you in writing why we believe we may have grounds to rescind your membership (completely void your membership so that no coverage ever existed). Our notice will tell you why we believe your application may be inaccurate or incomplete and invite you to provide us with additional medical or other information to help us confirm whether your actual health status at the time you were accepted for enrollment qualified you for individual plan enrollment.

We may rescind your membership if either of the following is true:

- We determine that you or someone on your behalf either intentionally or willfully gave us incomplete or incorrect material information about your current or past health in your Health Coverage Application (or at any time during the enrollment process), and our decision to accept your enrollment was based, in whole or in part, on the misinformation.
- We determine that you or someone on your behalf lied about your age, birthdate, or the nature of your relationship to the person who is financially responsible for your coverage, and our decision to accept your enrollment was based on this misinformation

We will send written notice to the Subscriber at least 30 days before we rescind your membership. Our notice will explain the basis for our decision and how you can appeal. If your membership is lawfully rescinded, you may be required to reimburse us for the reasonable value of any Services that we provided or that we paid for on your behalf under the *Membership Agreement and Evidence of Coverage,* if legally permitted. Within 30 days, we will refund all applicable Premiums except that we may subtract any amounts you owe us.

If your membership is rescinded, other Members in your Family may continue coverage. Please refer to the *Membership agreement and Evidence of Coverage* for more information.

If we rescind your membership, and you believe that our decision to rescind your membership was made in error, you can appeal that decision as described in the *Membership Agreement and Evidence of Coverage*.

Individual continuation of benefits for Dependents

If you no longer qualify as a Dependent, you may be eligible to enroll as a Subscriber without undergoing a medical review by applying within 31 days after your coverage ends.

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

Many Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Contact Center representatives are available to assist you 24 hours a day, seven days a week (except holidays, and after 5 p.m. the day after Thanksgiving, Christmas Eve, and New Year's Eve). toll free at **1-800-464-4000** (TTY users call **1-800-777-1370)**. For your convenience, you can also contact us through our Web site at **kp.org**.
Member Service representatives at our Plan Facilities and Member Service Contact Center can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace your ID card. These representatives can also help you if you need to file a claim.

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 are about an "adverse benefit determination" as defined in the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), 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 *Membership Agreement and Evidence of Coverage* for more information, including the complete arbitration provision.

Renewal provisions

If you comply with all of the terms of the *Membership Agreement and Evidence of Coverage*, we will automatically renew the *Membership Agreement and Evidence of Coverage* each year, effective on January 1 (if your most recent effective date of coverage is between January 1 and June 30), or July 1 (if you most recent effective date of coverage is between July 1 and December 31). Term of the *Membership Agreement and Evidence of Coverage* will remain the same when we renew it unless we have amended the *Membership Agreement and Evidence of Coverage.* **We may amend the *Membership Agreement and Evidence of Coverage* (including Premiums and benefits) at any time by sending written notice to the Subscriber at least 30 days before the effective date of the amendment** (if the Subscriber has chosen to receive agreements online we will notify the Subscriber at the most recent email address we have for the Subscriber when notices related to amendment of the *Membership Agreement and Evidence of Coverage* are posted on our Website at **kp.org**).

Principal exclusions, limitations, and reductions of benefits

Exclusions

The following are the principal exclusions from coverage. See the *Membership Agreement and Evidence of Coverage* for the complete list, including details and any exceptions to the exclusions. Also, additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the *Membership Agreement and Evidence of Coverage*.

- Care in a residential care facility or licensed intermediate care facility, unless otherwise stated in the *Membership Agreement and Evidence of Coverage*
- Chiropractic Services, unless otherwise stated in the *Membership Agreement and Evidence of Coverage*
- Artificial insemination, unless otherwise stated in the *Membership Agreement and Evidence of Coverage*, and conception by artificial means
- Cosmetic Services, except for Services covered under "Reconstructive Surgery" and "Prosthetic and Orthotic Devices" in the *Membership Agreement and Evidence of Coverage*
- 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 *Membership Agreement and Evidence of Coverage*
- 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 cancer 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 *Membership Agreement and Evidence of Coverage* for details about independent medical review and other dispute resolution options)
- Hearing Aids, unless otherwise stated in the *Membership Agreement and Evidence of Coverage*
- Items and services that are not health care items and services, unless otherwise stated in the *Membership Agreement and Evidence of Coverage*
- 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 *Membership Agreement and Evidence of Coverage*
- Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food
- 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 cancer clinical trials
- Services performed by unlicensed people, except for behavior health treatment covered under "Behavioral Helth Treatment for Pervasive Developmental Disorder or Autism" in the *Membership Agreement and Evidence of Coverage*

- 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 the diagnosis and treatment of infertility, unless otherwise stated in the *Membership Agreement and Evidence of Coverage*
- Services related to a noncovered Service, except for Services we would otherwise cover to treat complications of the noncovered Service
- Services to correct refractive defects of the eye (such as eye surgery or contact lenses to reshape the eye)
- Transgender surgery
- Travel and lodging expenses, unless otherwise stated in the *Membership Agreement and Evidence of Coverage*
- Treatment of hair loss or growth

Limitations

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

Additional limitations that apply only to a particular benefit are listed in the description of that benefit in the *Membership Agreement and Evidence of Coverage*

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 pay us Charges for those Services, except that the amount you must pay will not exceed the maximum amount allowed under California Civil Code Section 3040. Note: This "Reductions" section does not affect your obligation to pay Cost Sharing for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph. 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 *Membership Agreement and Evidence of Coverage* 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 Member. To apply for Kaiser Permanente Individuals and Families plan membership, simply return a Health Plan application and medical review form that includes information for each Member of your Family. You must provide medical review information for each person listed on the application form. If we approve your application, we will notify you of the date your coverage will begin and you can begin using our Services on the effective date of coverage indicated in our acceptance notice. Often, the effective date is the first day of the month following the date when we approve your application. Again, if you have any questions about Kaiser Permanente, please call our Member Service Contact Center toll free at **1-800-464-4000**.

Who may apply

The Subscriber must live in our Northern or Southern California Regions' Service Area at the time of enrollment (the Service Area where the Subscriber enrolls is your Home Region). This plan does not include dependent coverage, so each person in your family who is accepted for coverage must enroll as a Subscriber under his or her own *Membership Agreement and Evidence of Coverage*.

If you are age 19 or older, you can request enrollment at any time. To be accepted for coverage, you must pass medical review. Our decision to accept a dependent for coverage will be made only after we have thoroughly reviewed the health history information disclosed in the Health Coverage Application. Our review will include our

reasonable efforts to verify the accuracy and completeness of the health history information disclosed in the Health Coverage Application. The process of review and verification of applicant health history information is called medical review and we are under a duty to complete it.

If you are under age 19, we may receive your Health Coverage Application at any time. However, if you request enrollment during any of the following times, Premiums for your coverage may be lower:

- During the month that includes your birthday
- Within 63 days after any of the following:
  - you lose coverage due to termination of employment or change in your employment status or the employment status of the person through whom you were covered
  - an employer stopped contribution toward your coverage or the coverage of the person through whom you were covered
  - you lose Medicaid coverage (known as Medi-Cal in California), Access for Infants and Mothers Program coverage, or Children's Health Insurance Plan coverage (known as the Healthy Families Program in California) because you are no longer eligible for that coverage
  - you lose dependent coverage as a result of a death, legal separation, or divorce of the person through whom you were covered
  - you are born, adopted, or placed for adoption
  - you become a resident of California during a month that is not your birth month
  - the date a court order required someone to provide health coverage for you

Under federal law we may not decline a Health Coverage application for an applicant under age 19 due to preexisting medical conditions.

For more information, please refer to the *Membership Agreement and Evidence of Coverage*.

Persons barred from enrolling

- You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause
- Persons who have had entitlement to receive Services through Health Plan terminated twice in any 12-month period for failure to pay individual (nongroup) plan premiums cannot enroll for 12 months after the second termination date. For the purposes of this paragraph, a termination does not count if we reinstated your entitlement to receive Services because you made full payment on or before the next scheduled payment due date following the one you missed

Miscellaneous notices

Termination of a Plan Provider's contract

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care 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.

Completion of Services

If you are currently receiving covered Services in one of the following cases 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:

- 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
- We may cover Services for serious chronic conditions until the earlier of (1) 12 months from the termination date of the terminated provider, or (2) the first day after a course of treatment is complete, when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - it persists without full cure
  - it worsens over an extended period of time
  - it requires ongoing treatment to maintain remission or prevent deterioration

- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Care for children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the termination date of the terminated provider, or (2) 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 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 Service
- You are receiving Services in one of the cases listed above from the terminated Plan Provider on the provider's termination date
- 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 Services to be provided to you would be covered Services under the *Membership Agreement and Evidence of Coverage* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from the termination date of the Plan Provider

The Cost Sharing for completion of Services is the Cost Sharing required for Services provided by a Plan Provider as described in the *Membership Agreement and Evidence of Coverage*. **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

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

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

Please refer to *the Health Plan Benefits and Coverage Matrix* to learn if you have coverage for outpatient prescription drugs.

Health Insurance Counseling and Advocacy Program (HICAP)

For additional information concerning covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll free at **1-800-434-0222** (TTY users call **711**), for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

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.

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. 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 toll free at 1-800-464-4000. You can also find the notice at your local Plan Facility or on our Web site at kp.org.

Special note about Medicare

The information contained in this booklet is not applicable to most Medicare beneficiaries. If you are or become eligible for Medicare, you may be eligible to enroll in Kaiser Permanente Senior Advantage.

Definitions

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 Cost Sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract Cost Sharing

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service. A summary of Copayments and Coinsurance is listed in *the Health Plan Benefits and Coverage Matrix.* For the complete list of Copayments and Coinsurance, please refer to the *Membership Agreement and Evidence of Coverage*.

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 *the Health Plan Benefits and Coverage Matrix* For the complete list of Copayments and Coinsurance, please refer to the *Membership Agreement and Evidence of Coverage*.

Cost Sharing: The amount you are required to pay for a covered Service, for example, a Deductible, Copayment, or Coinsurance.

Deductible: The amount you must pay in a calendar year for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that calendar year. Any Deductible amounts are listed in *the Health Plan Benefits and Coverage Matrix.*

Dependent: A Member who meets the eligibility requirements as a Dependent as described in the *Membership Agreement and Evidence of Coverage*.

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

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

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect one of the following is true:

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

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

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

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

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

Home Region: Health Plan's Northern California Region or Southern California Region where you are enrolled.

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). In this *Disclosure Form*, Members who are "eligible for" Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who "have" Medicare Part A or B are those who have been granted Medicare Part A or B coverage.

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

Membership Agreement and Evidence of Coverage: The *Membership Agreement and Evidence of Coverage* document, describes your Health Plan coverage. To obtain a copy of the *Membership Agreement and Evidence of Coverage*, please call our Member Service Contact Center toll free at **1-800-464-4000**.

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

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

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

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

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

Plan Facility: Any facility listed in the enclosed facility listing or in a Kaiser Permanente guidebook (*Your Guidebook*) for your Home Region's Service Area, except that Plan Facilities are subject to change at any time without notice. For the current locations of Plan Facilities, please call our Member Service Contact Center toll free at 1-800-464-4000 (TTY users call **1-800-777-1370**).

Plan Hospital: Any hospital listed in the enclosed facility listing or in a Kaiser Permanente guidebook (*Your Guidebook*) for your Home Region's Service Area, except that Plan Hospitals are subject to change at any time without notice. For the current locations of Plan Hospitals, please call our Member Service Contact Center toll free at 1-800-464-4000 (TTY users call **1-800-777-1370**).

Plan Medical Office: Any medical office listed in the enclosed facility listing or in a Kaiser Permanente guidebook (*Your Guidebook*) for your Home Region's Service Area, except that Plan Medical Offices are subject to change at any time without notice. For the current locations of Plan Medical Offices, please call our Member Service Contact Center toll free at 1-800-464-4000 (TTY users call **1-800-777-1370**).

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Please refer to *Your Guidebook* for a list of Plan Pharmacies in your Home Region's Service Area, except that Plan Pharmacies are subject to change at any time without notice. For the current locations of Plan Pharmacies, please call our Member Service Contact Center toll free at 1-800-464-4000 (TTY users call **1-800-777-1370**).

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 we designate 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 after your treating physician determines that this condition is Stabilized.

Premiums: Periodic membership charges paid by or on behalf of each Member. Premiums are in addition to any Cost Sharing.

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

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. For information about Region locations in the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington, please call our Member Service Contact Center toll free at 1-800-464-4000 (TTY users call **1-800-777-1370**).

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, 94514, 94536–46, 94550–52, 94555, 94557, 94560, 94566, 94568, 94577–80, 94586–88, 94601–15, 94617–21, 94622–24, 94649, 94659–62, 94666, 94701–10, 94712, 94720, 95377, 95391

- The following ZIP codes in Amador County are inside our Service Area: 95640, 95669
- All ZIP codes in Contra Costa County are inside our Service Area: 94505–07, 94509, 94511, 94513–14, 94516–31, 94547–49, 94551, 94553, 94556, 94561, 94563–65, 94569–70, 94572, 94575, 94582–83, 94595–98, 94706–08, 94801–08, 94820, 94850
- The following ZIP codes in El Dorado County are inside our Service Area: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in Fresno County are inside our Service Area: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701-12, 93714–18, 93720-30, 93737, 93740–41, 93744–45, 93747, 93750, 93755, 93760-61, 93764–65, 93771–79, 93786, 93790–94, 93844, 93888
- The following ZIP codes in Kings County are inside our Service Area: 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in Madera County are inside our Service Area: 93601-02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- All ZIP codes in Marin County are inside our Service Area: 94901, 94903–04, 94912–15, 94920, 94924–25, 94929–30, 94933, 94937–42, 94945–50, 94956–57, 94960, 94963–66, 94970–71, 94973–74, 94976–79
- The following ZIP codes in Mariposa County are inside our Service Area: 93601, 93623, 93653
- The following ZIP codes in Napa County are inside our Service Area: 94503, 94508, 94515, 94558–59, 94562, 94567*, 94573–74, 94576, 94581, 94589–90, 94599, 95476

  *Knoxville is not in the Service Area
- The following ZIP codes in Placer County are inside our Service Area: 95602–04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95692, 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, 94246–50, 94252, 94254, 94256–59, 94261–63, 94267–69, 94271, 94273–74, 94277–80, 94282–91, 94293–98, 94571, 95608–11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638–41, 95652, 95655, 95660, 95662, 95670–71, 95673, 95680, 95683, 95690, 95693, 95741–42, 95757–59, 95763, 95811–38, 95840–43, 95851–53, 95860, 95864–67, 95887, 95894, 95899
- All ZIP codes in San Francisco County are inside our Service Area: 94102–05, 94107–12, 94114–27, 94129–34, 94137, 94139–47, 94151, 94156, 94158–64, 94172, 94177, 94188
- All ZIP codes in San Joaquin County are inside our Service Area: 94514, 95201–13, 95215, 95219–20, 95227, 95230–31, 95234, 95236–37, 95240–42, 95253, 95258, 95267, 95269, 95296–97, 95304, 95320, 95330, 95336–37, 95361, 95366, 95376–78, 95385, 95391, 95632, 95686, 95690
- All ZIP codes in San Mateo County are inside our Service Area: 94002, 94005, 94010–11, 94014–21, 94025–28, 94030, 94037–38, 94044, 94060–66, 94070, 94074, 94080, 94083, 94128, 94303, 94401–04, 94497
- The following ZIP codes in Santa Clara County are inside our Service Area: 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, 95196
- All ZIP codes in Solano County are inside our Service Area: 94510, 94512, 94533–35, 94571, 94585, 94589–92, 95616, 95620, 95625, 95687–88, 95690, 95694, 95696
- The following ZIP codes in Sonoma County are inside our Service Area: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492
- All ZIP codes in Stanislaus County are inside our Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322–23, 95326, 95328–29, 95350–58, 95360–61, 95363, 95367–68, 95380–82, 95385–87, 95397
- The following ZIP codes in Sutter County are inside our Service Area: 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95836–37
- The following ZIP codes in Tulare County are inside our Service Area: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- The following ZIP codes in Yolo County are inside our Service Area: 95605, 95607, 95612, 95616-18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- The following ZIP codes in Yuba County are inside our Service Area: 95692, 95903, 95961

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

- The following ZIP codes in Imperial County are inside our Service Area: 92274–75
- The following ZIP codes in Kern County are inside our Service Area: 93203, 93205-06, 93215–16, 93220, 93222, 93224–26, 93238, 93240–41, 93243, 93249–52, 93263, 93268, 93276, 93280, 93285, 93287, 93301–09, 93311–14, 93380, 93383–90, 93501–02, 93504–05, 93518–19, 93531, 93536, 93560–61, 93581
- The following ZIP codes in Los Angeles County are inside our Service Area: 90001–84, 90086–91, 90093–96, 90099, 90101, 90103, 90189, 90201–02, 90209–13, 90220–24, 90230–33, 90239–42, 90245, 90247–51, 90254–55, 90260–67, 90270, 90272, 90274–75, 90277–78, 90280, 90290–96, 90301–12, 90401–11, 90501–10, 90601–10, 90623, 90630–31, 90637–40, 90650–52, 90660–62, 90670–71, 90701–03, 90706–07, 90710–17, 90723, 90731–34, 90744–49, 90755, 90801–10, 90813–15, 90822, 90831–35, 90840, 90842, 90844, 90846–48, 90853, 90895, 90889, 91001, 91003, 91006–12, 91016–17, 91020–21, 91023–25, 91030–31, 91040–43, 91046, 91066, 91077, 91101–10, 91114–18, 91121, 91123–26, 91129, 91182, 91184–85, 91188–89, 91199, 91201–10, 91214, 91221–22, 91224–26, 91301–11, 91313, 91316, 91321–22, 91324–31, 91333–35, 91337, 91340–46, 91350–57, 91361–-62, 91364–65, 91367, 91371–72, 91376, 91380–87, 91390, 91392–96, 91401–13, 91416, 91423, 91426, 91436, 91470, 91482, 91495-96, 91499, 91501–08, 91510, 91521–23, 91526, 91601–12, 91614–18, 91702, 91706, 91709, 91711, 91714–16, 91722–24, 91731–35, 91740–41, 91744–50, 91754–56, 91765–73, 91775–76, 91778, 91780, 91788–93, 91795, 91801–04, 91896, 91899, 93243, 93510, 93532, 93534–36, 93539, 93543–44, 93550–53, 93560, 93563, 93584, 93586, 93590–91, 93599
- All ZIP codes in Orange County are inside our Service Area: 90620–24, 90630–33, 90638, 90680, 90720–21, 90740, 90742–43, 92602–07, 92609–10, 92612, 92614–20, 92623–30, 92637, 92646–63, 92672–79, 92683–85, 92688, 92690–94, 92697–98, 92701–08, 92711–12, 92728, 92735, 92780–82, 92799, 92801–09, 92811–12, 92814–17, 92821–23, 92825, 92831–38, 92840–46, 92850, 92856–57, 92859, 92861–71, 92885–87, 92899
- The following ZIP codes in Riverside County are inside our Service Area: 91752, 92201–03, 92210-11, 92220, 92223, 92230, 92234–36, 92240–41, 92247–48, 92253–55, 92258, 92260–64, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501-09, 92513–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92589–93, 92595–96, 92599, 92860, 92877–83
- The following ZIP codes in San Bernardino County are inside our Service Area: 91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758–59, 91761–64, 91766, 91784–86, 91792, 92252, 92256, 92268, 92277–78, 92284–86, 92305, 92307–08, 92313–18, 92321–22, 92324–26, 92329, 92331, 92333–37, 92339–41, 92344–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–95, 92397, 92399, 92401–08, 92410–15, 92418, 92423–24, 92427, 92880
- The following ZIP codes in San Diego County are inside our Service Area: 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–47, 91950–51, 91962–63, 91976–80, 91987, 92003, 92007–11, 92013–14, 92018–30, 92033, 92037–40, 92046, 92049, 92051–52, 92054–61, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92081–86. 92088, 92091–93, 92096, 92101–24, 92126–32, 92134–40, 92142–43, 92145, 92147, 92149-50, 92152–55, 92158–79, 92182, 92184, 92186-87, 92190–91, 92193, 92195–99
- The following ZIP codes in Ventura County are inside our Service Area: 90265, 91304, 91307, 91311, 91319–20, 91358–62, 91377, 93001–07, 93009–12, 93015–16, 93020–22, 93030–36, 93040–44, 93060–66, 93094, 93099, 93252

For each ZIP code listed for a county, our Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside our Service Area unless that other county is listed above and that ZIP code is also listed for that other county. If you have a question about whether a ZIP code is in our Service Area, please call our Member Service Contact Center.

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

Services: Health care services or items (“health care” includes both physical health care and mental health care) and behavioral health treatment covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the *Membership Agreement and Evidence of Coverage*.

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 for whom we have received applicable Premiums.

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

Your Kaiser Permanente Chiropractic Benefit for the Deductible 30/1500 Plan

Introduction

This document amends your Kaiser Foundation Health Plan, Inc. Deductible 30/1500 plan *Disclosure Form* to add coverage for Chiropractic Services.

Kaiser Foundation Health Plan, Inc. contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to make the ASH Plans network of Participating Chiropractors available to you. When you need chiropractic care, you have direct access to more than 3,100 licensed chiropractors in California.

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

This amendment is only a summary of your chiropractic coverage. The "Chiropractic Services Amendment" to your *Membership Agreement and Evidence of Coverage* provides details about the terms and conditions of your chiropractic coverage, including exclusions and limitations. To obtain the amendment to your *Membership Agreement and Evidence of Coverage*, please call our Member Service Call Center toll free at **1-800-464-4000**.

Participating Providers

The list of Participating Chiropractors are available on the ASH Plans Website at **ashcompanies.com/kp** or from the ASH Plans' Member Services Department at **1-800-678-9133** (TTY users call 711) weekdays from 5 a.m. to 6 p.m. The list of Participating Chiropractors are subject to change at any time without notice.

How to Obtain Services

You can obtain services from any ASH Plans' Participating Chiropractors without a referral from a Plan Physician.

To obtain services, call a Participating Chiropractor to schedule an initial examination. If additional Services are required, your Participating Chiropractor will prepare a Treatment Plan. The ASH Plans Clinical Services Manager will authorize the Treatment Plan if the Services are covered and the Services are Medically Necessary Chiropractic Services for you. For more information about how to obtain covered Chiropractic Services, please refer to the Chiropractic Services Amendment of your Health Plan *Membership Agreement and Evidence of Coverage*.

Second opinions

You may request a second opinion in regard to covered Service by contacting another Participating Chiropractor. Your visit to another Participating Chiropractor for a second opinion generally will count as one visit toward any calendar year visit limit. A Participating Chiropractor may also request a second opinion in regard to covered Services by referring you to another Participating Chiropractor in the same or similar specialty. When you are referred by a Participating Chiropractor to another Participating Chiropractor for a second opinion, your visit to the other Participating Chiropractor will not count toward any calendar year visit limit.

Your costs

When you receive covered Services, you must pay your Cost Sharing amount as described in the Chiropractic Services Amendment of your Health Plan *Membership Agreement and Evidence of Coverage*. The Cost Sharing does not apply toward the calendar year out-of-pocket maximum described in the Health Plan *Membership Agreement and Evidence of Coverage*.

ASH Plans Member Services

If you have question about the Services you can get from an ASH Plans Participating Provider, you may call ASH Plan Member Services toll free at **1-800-678-9133** (TTY users call 711) weekdays from 5 a.m. to 6 p.m.

Exclusions and Limitations

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

Definitions

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

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

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

Participating Chiropractor: A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide Medically Necessary Chiropractic Services to you. A list of Participating Chiropractors is available on the ASH Plans Web site at **ashcompanies.com/kp** or from the ASH Plans Member Services Department toll free at **1-800-678-9133** (TTY users call 711). The list of Participating Chiropractors is subject to change at any time, without notice. If you have questions, please call the ASH Plans Member Services Department.

Participating Provider: A Participating Chiropractor, or any licensed provider with which ASH Plans contracts to provide covered care, including laboratory tests or X-rays that are covered Chiropractic Services.

Treatment Plan: A proposed course of treatment for your Neuromusculoskeletal Disorder, which may include laboratory tests, X-rays, chiropractic appliances, and a specific number of visits for chiropractic manipulations, adjustments, and therapies that are Medically Necessary Chiropractic Services for you.

KAISER PERMANENTE®

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

Disclosure Form for Kaiser Permanente for Individuals and Families HSA-Qualified Deductible HMO Plan

Your Health Plan Coverage

Member Service Contact Center
24 hours a day, seven days a week
(except holidays, and after 5 p.m. the day after Thanksgiving, Christmas Eve, and New Year's Eve)
1-800-464-4000 toll free
1-800-777-1370 (toll free TTY for the hearing/speech impaired)
kp.org

Help in Your Language

Interpreters are available 24 hours a day, seven days a week, at no cost to you. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may be able to get materials written in your language. For more information, call our Member Service Contact Center at **1-800-464-4000** or **1-800-777-1370** (TTY) 24 hours a day, seven days a week (except holidays, and after 5 p.m. the day after Thanksgiving, Christmas Eve, and New Year's Eve).

Ayuda en su propio idioma

Tenemos disponibles intérpretes 24 horas al día, 7 días a la semana, sin ningún costo para usted. También podemos ofrecerle a usted, sus familiares y sus amigos cualquier tipo de ayuda que necesiten para tener acceso a nuestras instalaciones y servicios. Además, usted puede obtener materiales escritos en su idioma. Para más información, llame a nuestro Centro de Llamadas de Servicios a los Miembros al **1-800-788-0616** ó **1-800-777-1370** (TTY) los días de semana de 7 a.m. a 7 p.m., y los fines de semana de 7 a.m. a 3 p.m.

語言翻譯協助

提供　週七天，　天廿四小時翻譯。我們也向會員及其親友提供利用我處設施及服務所需之任何協助。此外會員還可索取以其母語編寫的資料。若需更多資訊，請於週一至週五上午七時至下午七時及週末上午七時至下午三時致電會員服務電話中心，電話號碼為 **1-800-757-7585** 或 **1-800-777-1370** （聽障專線）。

Health Plan Benefits and Coverage Matrix for the Deductible 0/1500 plan with HSA

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

The Services described below 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 Service Area, except where specifically noted to the contrary in the *Membership Agreement* (*Agreement*) for authorized referrals, visiting Member care, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

"Kaiser Permanente HSA-Qualified Deductible HMO Plan" is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. This health benefit plan is a High Deductible Health Plan. The health care coverage described in the *Agreement* is designed to be compatible for use with a Health Savings Account (HSA) under federal tax law.

Annual Out-of-Pocket Maximum	$3,000 per calendar year
You will not pay any more Cost Sharing during a calendar year if the Copayments, Coinsurance, and Deductible amounts you pay for Services add up to this amount.	
Deductible for Most Services	$1,500 per calendar year
For Services subject to the Deductible, you must pay Charges for Services you receive in a calendar year until you reach the Deductible amount. Note: The Deductible amount is subject to increase if the U.S. Department of the Treasury changes the minimum deductible required in High Deductible Health Plans.	
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	No charge after Deductible
Routine physical maintenance exams, including well-woman exams	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Deductible doesn't apply)
Family planning counseling and consultations	No charge (Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Deductible doesn't apply)
Eye exams for refraction	No charge after Deductible
Hearing exams	No charge (Deductible doesn't apply)
Urgent care consultations, exams, and treatment	No charge after Deductible
Physical, occupational, and speech therapy	No charge after Deductible
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$150 per procedure after Deductible
Allergy injections (including allergy serum)	No charge after Deductible
Most immunizations (including the vaccine)	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *Agreement*	No charge (Deductible doesn't apply)
MRI, most CT, and PET scans	$50 per procedure after Deductible
Health education:	
Covered individual health education counseling	No charge (Deductible doesn't apply)
Covered health education programs	No charge (Deductible doesn't apply)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$300 per day after Deductible
Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit after Deductible
Note: After you meet the Deductible, this Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).	

Ambulance Services	**You Pay**
Ambulance Services	$100 per trip after Deductible
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, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply after Deductible
Most generic refills through our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply after Deductible
Most brand-name items at a Plan Pharmacy	$35 for up to a 30-day supply, $70 for a 31- to 60-day supply, or $105 for a 61- to 100-day supply after Deductible
Most brand-name refills through our mail-order service	$35 for up to a 30-day supply or $70 for a 31- to 100-day supply after Deductible
Durable Medical Equipment	**You Pay**
The durable medical equipment for home use listed in the *Agreement* in accord with our durable medical equipment formulary guidelines (most durable medical equipment is **not covered**)	No charge after Deductible
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization (up to 30 days per calendar year)	$300 per day after Deductible
Outpatient mental health evaluation and treatment:	
Up to a total of 20 individual and group visits per calendar year that include Services for mental health evaluation or treatment	No charge after Deductible
Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	No charge after Deductible
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the *Agreement*.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	$300 per day after Deductible
Individual outpatient chemical dependency evaluation and treatment	No charge after Deductible
Group outpatient chemical dependency treatment	No charge after Deductible
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	No charge after Deductible
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge after Deductible
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge after Deductible
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the *Agreement* (most external prosthetic and orthotic devices are **not covered**)	No charge after Deductible
Hospice care	No charge after Deductible

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

Health Plan Benefits and Coverage Matrix for the Deductible 0/2700 plan with HSA

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

The Services described below 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 Service Area, except where specifically noted to the contrary in the *Membership Agreement* (*Agreement*) for authorized referrals, visiting Member care, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

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Annual Out-of-Pocket Maximum	$5,000 per calendar year
You will not pay any more Cost Sharing during a calendar year if the Copayments, Coinsurance, and Deductible amounts you pay for Services add up to this amount.	
Deductible for Most Services	$2,700 per calendar year
For Services subject to the Deductible, you must pay Charges for Services you receive in a calendar year until you reach the Deductible amount. Note: The Deductible amount is subject to increase if the U.S. Department of the Treasury changes the minimum deductible required in High Deductible Health Plans.	
Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	No charge after Deductible
Routine physical maintenance exams, including well-woman exams	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Deductible doesn't apply)
Family planning counseling and consultations	No charge (Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Deductible doesn't apply)
Eye exams for refraction	No charge after Deductible
Hearing exams	No charge (Deductible doesn't apply)
Urgent care consultations, exams, and treatment	No charge after Deductible
Physical, occupational, and speech therapy	No charge after Deductible
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$200 per procedure after Deductible
Allergy injections (including allergy serum)	No charge after Deductible
Most immunizations (including the vaccine)	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *Agreement*	No charge (Deductible doesn't apply)
MRI, most CT, and PET scans	$50 per procedure after Deductible
Health education:	
Covered individual health education counseling	No charge (Deductible doesn't apply)
Covered health education programs	No charge (Deductible doesn't apply)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	$400 per day after Deductible
Emergency Health Coverage	**You Pay**
Emergency Department visits	$100 per visit after Deductible
Note: After you meet the Deductible, this Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing).	
Ambulance Services	**You Pay**
Ambulance Services	$100 per trip after Deductible

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, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply after Deductible
Most generic refills through our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply after Deductible
Most brand-name items at a Plan Pharmacy	$35 for up to a 30-day supply, $70 for a 31- to 60-day supply, or $105 for a 61- to 100-day supply after Deductible
Most brand-name refills through our mail-order service	$35 for up to a 30-day supply or $70 for a 31- to 100-day supply after Deductible
Durable Medical Equipment	**You Pay**
The durable medical equipment for home use listed in the *Agreement* in accord with our durable medical equipment formulary guidelines (most durable medical equipment is **not covered**)	No charge after Deductible
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization (up to 30 days per calendar year)	$400 per day after Deductible
Outpatient mental health evaluation and treatment:	
Up to a total of 20 individual and group visits per calendar year that include Services for mental health evaluation or treatment	No charge after Deductible
Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	No charge after Deductible
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the *Agreement*.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	$400 per day after Deductible
Individual outpatient chemical dependency evaluation and treatment	No charge after Deductible
Group outpatient chemical dependency treatment	No charge after Deductible
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	No charge after Deductible
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge after Deductible
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge after Deductible
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the *Agreement* (most external prosthetic and orthotic devices are **not covered**)	No charge after Deductible
Hospice care	No charge after Deductible

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

Health Plan Benefits and Coverage Matrix for the Deductible 30/2700 plan with HSA

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

The Services described below 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 Service Area, except where specifically noted to the contrary in the *Membership Agreement* (*Agreement*) for authorized referrals, visiting Member care, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

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Annual Out-of-Pocket Maximum	$5,250 per calendar year
You will not pay any more Cost Sharing during a calendar year if the Copayments, Coinsurance, and Deductible amounts you pay for Services add up to this amount.	
Deductible for Most Services	$2,700 per calendar year
For Services subject to the Deductible, you must pay Charges for Services you receive in a calendar year until you reach the Deductible amount. Note: The Deductible amount is subject to increase if the U.S. Department of the Treasury changes the minimum deductible required in High Deductible Health Plans.	
Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$30 per visit after Deductible
Routine physical maintenance exams, including well-woman exams	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Deductible doesn't apply)
Family planning counseling and consultations	No charge (Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Deductible doesn't apply)
Eye exams for refraction	$30 per visit after Deductible
Hearing exams	No charge (Deductible doesn't apply)
Urgent care consultations, exams, and treatment	$30 per visit after Deductible
Physical, occupational, and speech therapy	$30 per visit after Deductible
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	30% Coinsurance after Deductible
Allergy injections (including allergy serum)	$5 per visit after Deductible
Most immunizations (including the vaccine)	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *Agreement*	No charge (Deductible doesn't apply)
MRI, most CT, and PET scans	$50 per procedure after Deductible
Health education:	
Covered individual health education counseling	No charge (Deductible doesn't apply)
Covered health education programs	No charge (Deductible doesn't apply)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	30% Coinsurance after Deductible
Emergency Health Coverage	**You Pay**
Emergency Department visits	30% Coinsurance after Deductible
Ambulance Services	**You Pay**
Ambulance Services	$100 per trip after Deductible

Prescription Drug Coverage	**You Pay**
The outpatient prescription drugs listed in the *Agreement* in accord with our drug formulary guidelines at Plan Pharmacies or through our mail-order service (most outpatient prescription drugs are **not covered**):	
Generic items	$10 for up to a 100-day supply after Deductible
Brand-name items	$35 for up to a 100-day supply after Deductible
Durable Medical Equipment	**You Pay**
The durable medical equipment for home use listed in the *Agreement* in accord with our durable medical equipment formulary guidelines (most durable medical equipment is **not covered**)	20% Coinsurance after Deductible
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization (up to 30 days per calendar year)	30% Coinsurance after Deductible
Outpatient mental health evaluation and treatment:	
Up to a total of 20 individual and group visits per calendar year that include Services for mental health evaluation or treatment	$30 per individual visit after Deductible $15 per group visit after Deductible
Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	$15 per visit after Deductible
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the *Agreement*.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	30% Coinsurance after Deductible
Individual outpatient chemical dependency evaluation and treatment	$30 per visit after Deductible
Group outpatient chemical dependency treatment	$5 per visit after Deductible
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission after Deductible
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge after Deductible
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	30% Coinsurance after Deductible
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the *Agreement* (most external prosthetic and orthotic devices are **not covered**)	No charge after Deductible
Hospice care	No charge after Deductible

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

Health Plan Benefits and Coverage Matrix for the Deductible 40/4000 plan with HSA

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

The Services described below 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 Service Area, except where specifically noted to the contrary in the *Membership Agreement* (*Agreement*) for authorized referrals, visiting Member care, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

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Annual Out-of-Pocket Maximum	$5,600 per calendar year
You will not pay any more Cost Sharing during a calendar year if the Copayments, Coinsurance, and Deductible amounts you pay for Services add up to this amount.	
Deductible for Most Services	$4,000 per calendar year
For Services subject to the Deductible, you must pay Charges for Services you receive in a calendar year until you reach the Deductible amount. Note: The Deductible amount is subject to increase if the U.S. Department of the Treasury changes the minimum deductible required in High Deductible Health Plans.	
Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$40 per visit after Deductible
Routine physical maintenance exams, including well-woman exams	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Deductible doesn't apply)
Family planning counseling and consultations	No charge (Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Deductible doesn't apply)
Eye exams for refraction	$40 per visit after Deductible
Hearing exams	No charge (Deductible doesn't apply)
Urgent care consultations, exams, and treatment	$40 per visit after Deductible
Physical, occupational, and speech therapy	$40 per visit after Deductible
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	30% Coinsurance after Deductible
Allergy injections (including allergy serum)	$5 per visit after Deductible
Most immunizations (including the vaccine)	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *Agreement*	No charge (Deductible doesn't apply)
MRI, most CT, and PET scans	$150 per procedure after Deductible
Health education:	
Covered individual health education counseling	No charge (Deductible doesn't apply)
Covered health education programs	No charge (Deductible doesn't apply)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	30% Coinsurance after Deductible
Emergency Health Coverage	**You Pay**
Emergency Department visits	30% Coinsurance after Deductible

Ambulance Services	**You Pay**
Ambulance Services	$150 per trip after Deductible
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, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply after Deductible
Most generic refills through our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply after Deductible
Most brand-name items at a Plan Pharmacy	$35 for up to a 30-day supply, $70 for a 31- to 60-day supply, or $105 for a 61- to 100-day supply after Deductible
Most brand-name refills through our mail-order service	$35 for up to a 30-day supply or $70 for a 31- to 100-day supply after Deductible
Durable Medical Equipment	**You Pay**
The durable medical equipment for home use listed in the *Agreement* in accord with our durable medical equipment formulary guidelines (most durable medical equipment is **not covered**)	20% Coinsurance after Deductible
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization (up to 30 days per calendar year)	30% Coinsurance after Deductible
Outpatient mental health evaluation and treatment:	
Up to a total of 20 individual and group visits per calendar year that include Services for mental health evaluation or treatment	$40 per individual visit after Deductible $20 per group visit after Deductible
Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	$20 per visit after Deductible
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the *Agreement*.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	30% Coinsurance after Deductible
Individual outpatient chemical dependency evaluation and treatment	$40 per visit after Deductible
Group outpatient chemical dependency treatment	$5 per visit after Deductible
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission after Deductible
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge after Deductible
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	30% Coinsurance after Deductible
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the *Agreement* (most external prosthetic and orthotic devices are **not covered**)	No charge after Deductible
Hospice care	No charge after Deductible

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

Health Plan Benefits and Coverage Matrix for the Deductible 50/5000 plan with HSA

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

The Services described below are covered only if all of the following conditions are satisfied:

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"Kaiser Permanente HSA-Qualified Deductible HMO Plan" is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. This health benefit plan is a High Deductible Health Plan. The health care coverage described in the *Agreement* is designed to be compatible for use with a Health Savings Account (HSA) under federal tax law.

Annual Out-of-Pocket Maximum	$6,000 per calendar year
You will not pay any more Cost Sharing during a calendar year if the Copayments, Coinsurance, and Deductible amounts you pay for Services add up to this amount.	
Deductible for Most Services	$5,000 per calendar year
For Services subject to the Deductible, you must pay Charges for Services you receive in a calendar year until you reach the Deductible amount. Note: The Deductible amount is subject to increase if the U.S. Department of the Treasury changes the minimum deductible required in High Deductible Health Plans.	
Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Most primary and specialty care consultations, exams, and treatment	$50 per visit after Deductible
Routine physical maintenance exams, including well-woman exams	No charge (Deductible doesn't apply)
Well-child preventive exams (through age 23 months)	No charge (Deductible doesn't apply)
Family planning counseling and consultations	No charge (Deductible doesn't apply)
Scheduled prenatal care exams	No charge (Deductible doesn't apply)
Eye exams for refraction	$50 per visit after Deductible
Hearing exams	No charge (Deductible doesn't apply)
Urgent care consultations, exams, and treatment	$50 per visit after Deductible
Physical, occupational, and speech therapy	$50 per visit after Deductible
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	30% Coinsurance after Deductible
Allergy injections (including allergy serum)	$5 per visit after Deductible
Most immunizations (including the vaccine)	No charge (Deductible doesn't apply)
Most X-rays and laboratory tests	$10 per encounter after Deductible
Preventive X-rays, screenings, and laboratory tests as described in the *Agreement*	No charge (Deductible doesn't apply)
MRI, most CT, and PET scans	$150 per procedure after Deductible
Health education:	
Covered individual health education counseling	No charge (Deductible doesn't apply)
Covered health education programs	No charge (Deductible doesn't apply)
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	30% Coinsurance after Deductible
Emergency Health Coverage	**You Pay**
Emergency Department visits	30% Coinsurance after Deductible
Ambulance Services	**You Pay**
Ambulance Services	$150 per trip after Deductible

Prescription Drug Coverage	You Pay
The outpatient prescription drugs listed in the *Agreement* in accord with our drug formulary guidelines at Plan Pharmacies or through our mail-order service (most outpatient prescription drugs are **not covered**)	$15 for up to a 30-day supply, $30 for a 31- to 60-day supply, or $45 for a 61- to 100-day supply after Deductible
Durable Medical Equipment	**You Pay**
The durable medical equipment for home use listed in the *Agreement* in accord with our durable medical equipment formulary guidelines (most durable medical equipment is **not covered**)	30% Coinsurance after Deductible
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization (up to 30 days per calendar year)	30% Coinsurance after Deductible
Outpatient mental health evaluation and treatment:	
Up to a total of 20 individual and group visits per calendar year that include Services for mental health evaluation or treatment	$50 per individual visit after Deductible $25 per group visit after Deductible
Up to 20 additional group visits in the same calendar year that meet Medical Group criteria	$25 per visit after Deductible
Note: Visit and day limits do not apply to Serious Emotional Disturbances of children and Severe Mental Illnesses as described in the *Agreement*.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	30% Coinsurance after Deductible
Individual outpatient chemical dependency evaluation and treatment	$50 per visit after Deductible
Group outpatient chemical dependency treatment	$5 per visit after Deductible
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission after Deductible
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge after Deductible
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	30% Coinsurance after Deductible
The external prosthetic devices, orthotic devices, and ostomy and urological supplies listed in the *Agreement* (most external prosthetic and orthotic devices are **not covered**)	No charge after Deductible
Hospice care	No charge after Deductible

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

Introduction

Welcome to Kaiser Permanente

When you join Kaiser Permanente, you get a health plan that's dedicated to your total well-being.

Our health education programs offer you great ways to protect and improve your health. You get a wealth of information online with kp.org. Save time in requesting routine appointments and prescription refills. Use the extensive health and drug encyclopedias to learn more about your health. Find Plan Facilities and providers close to home or work.

When you need medical care, we've got you covered. You can have a personal physician who understands your lifestyle. You can often take care of many health needs at one place, in one trip—from office consultations, exams, and treatment to laboratory tests, pharmacy, and X-rays. Most of our facilities provide same-day Urgent Care appointments, and many have evening and weekend appointments. And, you're not limited to receiving care from just one facility; you pick the Plan Facility that's most convenient for you. If you need specialty care, you have access to a wide array of medical specialties. You can even self-refer to selected specialties. And you can depend on the security of emergency coverage anywhere in the world.

We are committed to investing first and foremost in your health. From routine checkups to online services to Emergency Services, you can count on us to help you stay healthy.

About this booklet

This *Disclosure Form* summarizes some of the important features of your Kaiser Permanente membership, as well as general exclusions and limitations of your coverage. ***Please read the following information so that you will know from whom or what group of providers you may obtain health care. Also, you should read this*** **Disclosure Form** ***and the*** **Membership Agreement and Evidence of Coverage** ***carefully if you have special health care needs.***

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." Your Home Region is the Service Area where you are enrolled. This *Disclosure Form* describes your coverage in your Home Region. Also, this *Disclosure Form* describes different benefit plans, for example benefit plans that include Deductibles for specified Services. Everything in this section of the *Disclosure Form* applies to all benefit plans, except as otherwise indicated. Please see the Health Plan Benefits and Coverage Matrix for a summary of Deductibles, Copayments, and Coinsurance. If you have questions about benefits, please call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**) or refer to the *Membership Agreement and Evidence of Coverage*

Some capitalized terms have special meaning in this *Disclosure Form,* as described in the "Definitions" section at the end of this booklet. Once you become a Kaiser Permanente member, we will send you a *Membership Agreement and Evidence of Coverage* with your acceptance notice. Your *Membership Agreement and Evidence of Coverage* provides details about the terms and conditions of your coverage. This *Disclosure Form* is only a summary. A *Membership Agreement and Evidence of Coverage* is available by calling our Member Service Contact Center toll free at **1-800-464-4000** if you would like to review one before being accepted for membership.

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 toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**), 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.

Kaiser Permanente HSA – Qualified Deductible HMO Plan

"Kaiser Permanente HSA - Qualified HMO Deductible Plan" is a health benefit plan that meets the requirements of Section 223(c)(2) of the Internal Revenue Code. This health benefit plan is a High Deductible Health Plan. The health care coverage described in the *Membership Agreement and Evidence of Coverage* is designed to be compatible for use with a Health Savings Account (HSA) under federal tax law.

The tax references contained in this *Disclosure Form* relate to federal income tax only. The tax treatment of Health Savings Account (HSA) contributions and distributions under your state's income tax laws may differ from the federal tax treatment, and differs from state to state. Health Plan does not provide tax advice. You should consult with your financial or tax advisor for tax advice or more information, including information about your eligibility for a Health Savings Account.

Please be aware that enrollment in a High Deductible Health Plan that is HSA-compatible is only one of the eligibility requirements for establishing and contributing to a Health Savings Account. Some examples of other requirements include that you must not be:

- Covered by another health coverage plan that is not also an HSA-compatible plan, with certain exceptions
- Have Medicare Part A or B
- Able to be claimed as a dependent on another person's tax return

How to obtain care

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 *Membership Agreement and Evidence of Coverage* 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 care

For Plan Facility locations, please refer to the enclosed facility listing, *Your Guidebook to Kaiser Permanente Services (Your Guidebook),* our Web site at **kp.org**, or your local telephone book under "Kaiser Permanente."

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.

Post-Stabilization Care. Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that this condition is Stabilized. We cover Post-Stabilization Care from a Non–Plan Provider, including inpatient care at a Non–Plan Hospital, only if we provide prior authorization for the care (prior authorization means that we must approve the Services in advance).

To request authorization to receive Post-Stabilization Care from a Non–Plan Provider, you must call us toll free at **1-800-225-8883** (TTY users call **711**) or the notification telephone number on your Kaiser Permanente ID card *before* you receive the care if it is reasonably possible to do so (otherwise, call us as soon as reasonably possible). Be sure to ask the Non–Plan Provider to tell you what care (including any

transportation) we have authorized since we do not cover unauthorized Post-Stabilization Care or related transportation provided by Non–Plan Providers.

Please refer to the *Membership Agreement and Evidence of Coverage* for coverage information, exclusions, and limitations.

Urgent Care

Inside your Home Region Service Area. If you think you may need Urgent Care, all the appropriate appointment or advice nurse telephone number at a Plan Facility. Please refer to *Your Guidebook* for advice nurse and Plan Facility telephone numbers.

Out-of Area urgent Care. If you have an Urgent Care need 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
- 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

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

Your ID card

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

If you need to get care before you receive your ID card, but after you have received your acceptance notice, when you make an appointment or get covered care, simply say that you are a new individual plan Member and give your medical record number and the effective date of coverage, both of which are on the acceptance notice.

Interpreter Services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services are available 24 hours a day, seven days a week, at no cost to you. For more information about the interpreter services we offer, please call our Member Service Contact Center.

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 facility locations, please refer to the enclosed facility listing or call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**).

- 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* for Emergency Department locations in your area)
- Same-day Urgent Care appointments are available at many locations (please refer to *Your Guidebook* 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* for locations in your area)

Plan Medical Offices and Plan Hospitals for your area are listed in *Your Guidebook. 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 periodically updated. We will mail you *Your Guidebook* after you've enrolled. If you do not receive a copy or need another copy, call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**, 24 hours a day, seven days a week (except holidays, and after 5 p.m. the day after Thanksgiving, Christmas Eve, and New Year's Eve). You can also download a copy from our Web site at **kp.org**.

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 for any reason. To learn how to select a personal Plan Physician, please call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**). You can find a directory of our Plan Physicians on our Web site at **kp.org**. For the current list of physicians who are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook*.

Getting a referral

Referrals to Plan Providers

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

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

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

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

Medical Group authorization procedure for certain referrals

The following 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.** If your Plan Physician prescribes durable medical equipment, he or she will submit a written referral to the Plan Hospital's durable medical equipment coordinator, who will authorize the durable medical equipment if he or she determines that your durable medical equipment coverage includes the item and that the item is listed on our formulary for your condition. If the item doesn't appear to meet our durable medical equipment formulary guidelines, then the durable medical equipment coordinator will contact the Plan Physician for additional information. If the durable medical equipment request still doesn't appear to meet our durable medical equipment formulary guidelines, it

will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our durable medical equipment formulary, please refer to the *Membership Agreement and Evidence of Coverage*

- **Ostomy and urological supplies.** If your Plan Physician prescribes ostomy or urological supplies, he or she will submit a written referral to the Plan Hospital's designated coordinator, who will authorize the item if he or she determines that it is covered and the item is listed on our soft goods formulary for your condition. If the item doesn't appear to meet our soft goods formulary guidelines, then the coordinator will contact the Plan Physician for additional information. If the request still doesn't appear to meet our soft goods formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our soft goods formulary, please refer to the *Membership Agreement and Evidence of Coverage*
- **Services not available from Plan Providers.** If your Plan Physician decides that you require covered Services not available from Plan Providers, he or she will recommend to the Medical Group that you be referred to a Non–Plan Provider inside or outside your Home Region's Service Area. The appropriate Medical Group designee will authorize the Services if he or she determines that they are Medically Necessary and are not available from a Plan Provider. Referrals to Non–Plan Physicians will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your Plan Physician what Services have been authorized
- **Transplants.** If your Plan Physician makes a written referral for a transplant, the Medical Group's regional transplant advisory committee or board (if one exists) will authorize the Services if it determines that they are Medically Necessary. In cases where no transplant committee or board exists, the Medical Group will refer you to physician(s) at a transplant center, and the Medical Group will authorize the Services if the transplant center's physician(s) determine that they are Medically Necessary. Note: A Plan Physician may provide or authorize a corneal transplant without using this Medical Group transplant authorization procedure

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 and other Services that are subject to an authorization procedure, please refer to the *Membership Agreement and Evidence of Coverage* or call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**).

Second opinions

If you want a second opinion, you can either ask your personal Plan Physician to help you arrange for one, or you can make an appointment with another Plan Physician who is an appropriately qualified medical professional for your condition. For more information, please refer to the *Membership Agreement and Evidence of Coverage*.

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 ask your Plan Physician or call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**).

Your costs

Cost Sharing (Deductibles, Copayments, and Coinsurance)

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

- You receive Services during your visit that were not scheduled when you made your payment at check in
- You receive Services from a second provider during your visit that were not scheduled when you made your payment at check in
- You go in for Preventive Care Services and receive non-preventive Services during your visit that were not scheduled when you made your payment at check in
- You go in for Preventive Care Services and receive non-preventive Services during your visit that were not scheduled when you made your payment at check in
- You go in for Preventive Care Services and instead receive non-preventive Services during your visit
- At check-in, you ask to be billed for some or all of the Cost Sharing for the Services you will receive, and we agree to bill you
- Medical Group authorizes a referral to a Non-Plan Provider and the provider does not collect Cost Sharing a the time you receive Services

If you have questions about Cost Sharing for specific Services that you are scheduled to receive or that your provider orders during a visit or procedure, please visit our website at **kp.org/memberestimates** to use our Cost Sharing estimate tool or call our Member Service Contact Center weekdays 7 a.m. to 5 p.m. toll free at 1-800-390-3507 (TTY users call 1-800-777-1370).

Copayments and Coinsurance

A summary of Copayments and Coinsurance is listed in *the Health Plan Benefits and Coverage Matrix*. Please refer to the "Benefits and Cost Sharing" section of the *Membership Agreement and Evidence of Coverage* for the complete list of Copayments and Coinsurance.

Deductibles

All covered Services are subject to the Deductible except certain preventive care Services. You must pay Charges for Services subject to the Deductible until you meet the Deductible each calendar year. The only payments that count toward a Deductible are those you make for covered Services that are subject to the Deductible.

After you meet the Deductible and for the remainder of that calendar year, you pay the applicable Copayment or Coinsurance, subject to the annual out-of-pocket maximum

A summary of which Services are subject to the Deductible is listed in *the Health Plan Benefits and Coverage Matrix*.When the Copayment or Coinsurance for a particular Service is described as "after Deductible," and you have not met the Deductible, you must pay Charges for those Services. Please refer to the "Benefits and Cost Sharing" section of the *Membership Agreement and Evidence of Coverage* for the complete list of the Services that are subject to the Deductible.

If you would like an estimate of the Charges for a Service before you schedule an appointment or procedure, please visit our website at **kp.org/memberestimates** to use our Cost Sharing estimate tool or call our Member Service Contact Center weekdays 7 a.m. to 5 p.m. toll free at **1-800-390-3507** (TTY users call **1-800-777-1370**).

When you pay Charges for Services subject to the Deductible, we will give you a receipt and we will send you a Summary of Accumulation. The Summary of Accumulation will include the total amounts you have paid toward your Deductible and toward your annual out-of-pocket maximum. You can also obtain a copy of this Summary of Accumulation from our Member Service Contact Center toll free at **1-800-390-3507**.

Please refer to *the Health Plan Benefits and Coverage Matrix* to learn of the amount of the Deductible. Please refer to the *Membership Agreement and Evidence of Coverage* for more information about Deductibles.

Annual out-of-pocket maximum

There is a limit to the total amount of Cost Sharing you must pay in a calendar year for all of the covered Services you receive in the same calendar year. The limit amounts are specified in *the Health Plan Benefits and Coverage Matrix.*

When you pay Cost Sharing that applies toward the annual out-of-pocket maximum, we will give you a receipt, and we will send you a Summary of Accumulation. The Summary of Accumulation will include the amounts you have paid toward your Deductible and toward your annual out-of-pocket maximum.

Payment of Premiums

Only Members for whom we have received the appropriate Premiums are entitled to coverage, and then only for the period for which we have received payment. You must prepay Premiums listed on the enclosed rate chart, applicable to your coverage, for each month on or before the last day of the preceding month. Your Premiums may change if you move to a new rate area.

Surcharge on Premiums for children under age 19. Premiums for the child will be subject to a 20% surcharge for a period of 12 months if both of the following are true on the date the person requesting the child's enrollment signed the child's application:

- The child did not have health care coverage for the previous 90 days
- Enrollment was not requested within 63 days of one of the following events:
  - the child is born, adopted, or placed for adoption
  - the child becomes a resident of California during the month that is not their birth month
  - the date a court order required someone to provide health care coverage for the child

When Premiums for the child are subject to this surcharge, the Premiums listed on the Rate Sheet applicable to the child's coverage will include the surcharge. At the end of that 12-month period, the surcharge will be automatically discontinued.

Financial liability

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for 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 covered care 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 "Termination of a Plan Provider's contract" 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, Out-of-Area Urgent Care from a Non–Plan Provider, or if you receive emergency ambulance Services, you must pay for the Services unless the provider agrees to bill us. If you want us to pay for the Services you must file a claim. We will reduce any payment we make to you or the Non–Plan Provider by applicable Cost Sharing.

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

- As soon as possible, request our claim form by calling our Member Service Contact Center toll free at **1-800-464-4000** or **1-800-390-3510** (TTY users call **1-800-777-1370**). 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 Sharing 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 *Membership Agreement and Evidence of Coverage* for additional instructions, coverage information, exclusions, limitations, and dispute resolution for denied claims.

Termination of benefits

You may terminate your membership by sending written notice, signed by the Subscriber, to the address below. Your membership will terminate at 11:59 p.m. on the last day of the month in which we receive your notice. Also, you must include with your notice all amounts payable related to the *Membership Agreement and Evidence of Coverage*, including Premiums, for the period prior to your termination date.

For Northern California Region Members:
Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 23059
San Diego, CA 92193-3059

For Southern California Region Members:
Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 23127
San Diego, CA 92193-3127

After your membership terminates, you will be billed as a non-Member for any Services you receive.

Membership will cease for the Subscriber if:

- The *Membership Agreement and Evidence of Coverage* between you and Health Plan is terminated for any reason
- You are no longer eligible for coverage as described in the *Membership Agreement and Evidence of Coverage*
- You intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider. We may terminate your membership immediately by sending written notice to the Subscriber. Termination will be effective on the date we send the notice and you will not be allowed to enroll in Health Plan in the future
- You fail to pay us the appropriate Premiums for your Family. If we terminate your membership because we did not receive the required Premiums when due, your coverage will continue during a 30 day grace period, but upon termination you will be responsible for paying all past due Premiums, including the Premiums for this grace period. Persons terminated for nonpayment may not enroll in Health Plan even after paying all amounts owed unless we approve the enrollment. Also, you must undergo a medical review unless we reinstate your membership without a lapse in coverage

Rescission of membership

In order for us to accept you for enrollment, you must meet eligibility requirements and undergo a medical review of the health history information you provided in your Health Coverage Application, including information provided during the enrollment process. Our decision to accept you (or any other applicant on this application) for coverage will be made only after we have thoroughly reviewed the health history information pertaining to you (and any other applicants) disclosed in the health coverage Application. Our review will include our reasonable efforts to verify the accuracy and completeness of the health history information disclosed in the Health Coverage Application. The process of review and verification of applicant health history information is called medical review and we are under a duty to complete it.

If we approved your application for membership without properly completing medical review, we may only rescind your membership if we can support a claim that you or someone on your behalf willfully misrepresented your health history information disclosed in the Health Coverage Application.

If we find a material inconsistency between your actual health status on the date your were accepted for enrollment and the information provided in your Health Coverage Application, we will notify you in writing why we believe we may have grounds to rescind your membership (completely void your membership so that no coverage ever existed). Our notice will tell you why we believe your application may be inaccurate or incomplete and invite you to provide us with additional medical or other information to help us confirm whether your actual health status at the time you were accepted for enrollment qualified you for individual plan enrollment.

We may rescind your membership if either of the following is true:

- We determine that you or someone on your behalf either intentionally or willfully gave us incomplete or incorrect material information about your current or past health in your Health Coverage Application (or at any time during the enrollment process), and our decision to accept your enrollment was based, in whole or in part, on the misinformation.
- We determine that you or someone on your behalf lied about your age, birthdate, or the nature of your relationship to the person who is financially responsible for your coverage, and our decision to accept your enrollment was based on this misinformation

We will send written notice to the Subscriber at least 30 days before we rescind your membership. Our notice will explain the basis for our decision and how you can appeal. If your membership is lawfully rescinded, you may be required to reimburse us for the reasonable value of any Services that we provided or that we paid for on your behalf under the *Membership Agreement and Evidence of Coverage,* if legally permitted. Within 30 days, we will refund all applicable Premiums except that we may subtract any amounts you owe us.

If your membership is rescinded, other Members in your Family may continue coverage. Please refer to the *Membership agreement and Evidence of Coverage* for more information.

If we rescind your membership, and you believe that our decision to rescind your membership was made in error, you can appeal that decision as described in the *Membership Agreement and Evidence of Coverage*.

Individual continuation of benefits for Dependents

If you no longer qualify as a Dependent, you may be eligible to enroll as a Subscriber without undergoing a medical review by applying within 31 days after your coverage ends.

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

Many Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Contact Center representatives are available to assist you 24 hours a day, seven days a week (except holidays, and after 5 p.m. the day after Thanksgiving, Christmas Eve, and New Year's Eve). toll free at **1-800-464-4000** (TTY users call **1-800-777-1370)**. For your convenience, you can also contact us through our Web site at **kp.org**.

Member Service representatives at our Plan Facilities and Member Service Contact Center can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what

to do if you move, what to do if you need care while you are traveling, and how to replace your ID card. These representatives can also help you if you need to file a claim.

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 are about an "adverse benefit determination" as defined in the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), 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 *Membership Agreement and Evidence of Coverage* for more information, including the complete arbitration provision.

Renewal provisions

If you comply with all of the terms of the *Membership Agreement and Evidence of Coverage*, we will automatically renew the *Membership Agreement and Evidence of Coverage* each year, effective on January 1 (if your most recent effective date of coverage is between January 1 and June 30), or July 1 (if you most recent effective date of coverage is between July 1 and December 31). Term of the *Membership Agreement and Evidence of Coverage* will remain the same when we renew it unless we have amended the *Membership Agreement and Evidence of Coverage.* **We may amend the *Membership Agreement and Evidence of Coverage* (including Premiums and benefits) at any time by sending written notice to the Subscriber at least 30 days before the effective date of the amendment** (if the Subscriber has chosen to receive agreements online we will notify the Subscriber at the most recent email address we have for the Subscriber when notices related to amendment of the *Membership Agreement and Evidence of Coverage* are posted on our Website at **kp.org**).

Principal exclusions, limitations, and reductions of benefits

Exclusions

The following are the principal exclusions from coverage. See the *Membership Agreement and Evidence of Coverage* for the complete list, including details and any exceptions to the exclusions. Also, additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the *Membership Agreement and Evidence of Coverage.*

- Care in a residential care facility or licensed intermediate care facility, unless otherwise stated in the *Membership Agreement and Evidence of Coverage*
- Chiropractic Services, unless otherwise stated in the *Membership Agreement and Evidence of Coverage*

- Artificial insemination, unless otherwise stated in the *Membership Agreement and Evidence of Coverage*, and conception by artificial means
- Cosmetic Services, except for Services covered under "Reconstructive Surgery" and "Prosthetic and Orthotic Devices" in the *Membership Agreement and Evidence of Coverage*
- 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 *Membership Agreement and Evidence of Coverage*
- 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 cancer 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 *Membership Agreement and Evidence of Coverage* for details about independent medical review and other dispute resolution options)
- Hearing Aids, unless otherwise stated in the *Membership Agreement and Evidence of Coverage*
- Items and services that are not health care items and services, unless otherwise stated in the *Membership Agreement and Evidence of Coverage*
- 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 *Membership Agreement and Evidence of Coverage*
- Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food
- 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 cancer clinical trials
- Services performed by unlicensed people, except for behavior health treatment covered under "Behavioral Helth Treatment for Pervasive Developmental Disorder or Autism" in the *Membership Agreement and Evidence of Coverage*
- 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 the diagnosis and treatment of infertility, unless otherwise stated in the *Membership Agreement and Evidence of Coverage*
- Services related to a noncovered Service, except for Services we would otherwise cover to treat complications of the noncovered Service
- Services to correct refractive defects of the eye (such as eye surgery or contact lenses to reshape the eye)
- Transgender surgery
- Travel and lodging expenses, unless otherwise stated in the *Membership Agreement and Evidence of Coverage*
- Treatment of hair loss or growth

Limitations

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

Additional limitations that apply only to a particular benefit are listed in the description of that benefit in the *Membership Agreement and Evidence of Coverage*

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 pay us Charges for those Services, except that the amount you must pay will not exceed the maximum amount allowed under California Civil Code Section 3040. Note: This "Reductions" section does not affect your obligation to pay Cost Sharing for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph. 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 *Membership Agreement and Evidence of Coverage* 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 Member. To apply for Kaiser Permanente Individuals and Families plan membership, simply return a Health Plan application and medical review form that includes information for each Member of your Family. You must provide medical review information for each person listed on the application form. If we approve your application, we will notify you of the date your coverage will begin and you can begin using our Services on the effective date of coverage indicated in our acceptance notice. Often, the effective date is the first day of the month following the date when we approve your application. Again, if you have any questions about Kaiser Permanente, please call our Member Service Contact Center toll free at **1-800-464-4000**.

Who may apply

The Subscriber must live in our Northern or Southern California Regions' Service Area at the time of enrollment (the Service Area where the Subscriber enrolls is your Home Region). This plan does not include dependent coverage, so each person in your family who is accepted for coverage must enroll as a Subscriber under his or her own *Membership Agreement and Evidence of Coverage*.

If you are age 19 or older, you can request enrollment at any time. To be accepted for coverage, you must pass medical review. Our decision to accept a dependent for coverage will be made only after we have thoroughly reviewed the health history information disclosed in the Health Coverage Application. Our review will include our reasonable efforts to verify the accuracy and completeness of the health history information disclosed in the Health Coverage Application. The process of review and verification of applicant health history information is called medical review and we are under a duty to complete it.

If you are under age 19, we may receive your Health Coverage Application at any time. However, if you request enrollment during any of the following times, Premiums for your coverage may be lower:

- During the month that includes your birthday
- Within 63 days after any of the following:
  - you lose coverage due to termination of employment or change in your employment status or the employment status of the person through whom you were covered
  - an employer stopped contribution toward your coverage or the coverage of the person through whom you were covered
  - you lose Medicaid coverage (known as Medi-Cal in California), Access for Infants and Mothers Program coverage, or Children's Health Insurance Plan coverage (known as the Healthy Families Program in California) because you are no longer eligible for that coverage
  - you lose dependent coverage as a result of a death, legal separation, or divorce of the person through whom you were covered
  - you are born, adopted, or placed for adoption
  - you become a resident of California during a month that is not your birth month
  - the date a court order required someone to provide health coverage for you

Under federal law we may not decline a Health Coverage application for an applicant under age 19 due to preexisting medical conditions.

For more information, please refer to the *Membership Agreement and Evidence of Coverage*.

Persons barred from enrolling

- You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause
- Persons who have had entitlement to receive Services through Health Plan terminated twice in any 12-month period for failure to pay individual (nongroup) plan premiums cannot enroll for 12 months after the second termination date. For the purposes of this paragraph, a termination does not count if we reinstated your entitlement to receive Services because you made full payment on or before the next scheduled payment due date following the one you missed

Miscellaneous notices

Termination of a Plan Provider's contract

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care 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.

Completion of Services

If you are currently receiving covered Services in one of the following cases 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:

- 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
- We may cover Services for serious chronic conditions until the earlier of (1) 12 months from the termination date of the terminated provider, or (2) the first day after a course of treatment is complete, when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - it persists without full cure
  - it worsens over an extended period of time
  - it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Care for children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the termination date of the terminated provider, or (2) 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 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 Service
- You are receiving Services in one of the cases listed above from the terminated Plan Provider on the provider's termination date

- 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 Services to be provided to you would be covered Services under the *Membership Agreement and Evidence of Coverage*if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from the termination date of the Plan Provider

The Cost Sharing for completion of Services is the Cost Sharing required for Services provided by a Plan Provider as described in the *Membership Agreement and Evidence of Coverage*. **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

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

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

Please refer to *the Health Plan Benefits and Coverage Matrix* to learn if you have coverage for outpatient prescription drugs.

Health Insurance Counseling and Advocacy Program (HICAP)

For additional information concerning covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll free at **1-800-434-0222** (TTY users call **711**), for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

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.

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. 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 toll free at 1-800-464-4000. You can also find the notice at your local Plan Facility or on our Web site at kp.org.

Definitions

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 Cost Sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract Cost Sharing

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service. A summary of Copayments and Coinsurance is listed in *the Health Plan Benefits and Coverage Matrix.* For the complete list of Copayments and Coinsurance, please refer to the *Membership Agreement and Evidence of Coverage*.

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 *the Health Plan Benefits and Coverage Matrix* For the complete list of Copayments and Coinsurance, please refer to the *Membership Agreement and Evidence of Coverage*.

Cost Sharing: The amount you are required to pay for a covered Service, for example, a Deductible, Copayment, or Coinsurance.

Deductible: The amount you must pay in a calendar year for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that calendar year. Deductible amounts are listed in *the Health Plan Benefits and Coverage Matrix*.

Dependent: A Member who meets the eligibility requirements as a Dependent as described in the *Membership Agreement and Evidence of Coverage*.

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

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

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect one of the following is true:

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

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

- A medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition

- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post Stabilization Care and not Emergency Services)

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

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. 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: 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 a High Deductible Health Plan compatible for use with a Health Savings Account.

Home Region: Health Plan's Northern California Region or Southern California Region where you are enrolled.

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). In this *Disclosure Form*, Members who are "eligible for" Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who "have" Medicare Part A or B are those who have been granted Medicare Part A or B coverage. If you have Medicare Part A or B, you are ineligible to establish or contribute to a Health Savings Account.

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."

Membership Agreement and Evidence of Coverage: The *Membership Agreement and Evidence of Coverage* document, describes your Health Plan coverage. To obtain a copy of the *Membership Agreement and Evidence of Coverage*, please call our Member Service Contact Center toll free at **1-800-464-4000**.

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

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

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

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

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

Plan Facility: Any facility listed in the enclosed facility listing or in a Kaiser Permanente guidebook (*Your Guidebook*) for your Home Region's Service Area, except that Plan Facilities are subject to change at any

time without notice. For the current locations of Plan Facilities, please call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**).

Plan Hospital: Any hospital listed in the enclosed facility listing or in a Kaiser Permanente guidebook (*Your Guidebook*) for your Home Region's Service Area, except that Plan Hospitals are subject to change at any time without notice. For the current locations of Plan Hospitals, please call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**).

Plan Medical Office: Any medical office listed in the enclosed facility listing or in a Kaiser Permanente guidebook (*Your Guidebook*) for your Home Region's Service Area, except that Plan Medical Offices are subject to change at any time without notice. For the current locations of Plan Medical Offices, please call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**).

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Please refer to *Your Guidebook* for a list of Plan Pharmacies in your Home Region's Service Area, except that Plan Pharmacies are subject to change at any time without notice. For the current locations of Plan Pharmacies, please call our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**).

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 we designate 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 after your treating physician determines that this condition is Stabilized.

Premiums: Periodic membership charges paid by or on behalf of each Member. Premiums are in addition to any Cost Sharing.

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

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. For information about Region locations in the District of Columbia and parts of California, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington, please call our Member Service Contact Center toll free at 1-800-464-4000 (TTY users call **1-800-777-1370**).

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, 94514, 94536–46, 94550–52, 94555, 94557, 94560, 94566, 94568, 94577–80, 94586–88, 94601–15, 94617–21, 94622–24, 94649, 94659–62, 94666, 94701–10, 94712, 94720, 95377, 95391
- The following ZIP codes in Amador County are inside our Service Area: 95640, 95669
- All ZIP codes in Contra Costa County are inside our Service Area: 94505–07, 94509, 94511, 94513–14, 94516–31, 94547–49, 94551, 94553, 94556, 94561, 94563–65, 94569–70, 94572, 94575, 94582–83, 94595–98, 94706–08, 94801–08, 94820, 94850
- The following ZIP codes in El Dorado County are inside our Service Area: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in Fresno County are inside our Service Area: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701-12, 93714–18, 93720-30, 93737, 93740–41, 93744–45, 93747, 93750, 93755, 93760-61, 93764–65, 93771–79, 93786, 93790–94, 93844, 93888
- The following ZIP codes in Kings County are inside our Service Area: 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in Madera County are inside our Service Area: 93601-02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720

- All ZIP codes in Marin County are inside our Service Area: 94901, 94903–04, 94912–15, 94920, 94924–25, 94929–30, 94933, 94937–42, 94945–50, 94956–57, 94960, 94963–66, 94970–71, 94973–74, 94976–79
- The following ZIP codes in Mariposa County are inside our Service Area: 93601, 93623, 93653
- The following ZIP codes in Napa County are inside our Service Area: 94503, 94508, 94515, 94558–59, 94562, 94567*, 94573–74, 94576, 94581, 94589–90, 94599, 95476

  *Knoxville is not in the Service Area
- The following ZIP codes in Placer County are inside our Service Area: 95602–04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95692, 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, 94246–50, 94252, 94254, 94256–59, 94261–63, 94267–69, 94271, 94273–74, 94277–80, 94282–91, 94293–98, 94571, 95608–11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638–41, 95652, 95655, 95660, 95662, 95670–71, 95673, 95680, 95683, 95690, 95693, 95741–42, 95757–59, 95763, 95811–38, 95840–43, 95851–53, 95860, 95864–67, 95887, 95894, 95899
- All ZIP codes in San Francisco County are inside our Service Area: 94102–05, 94107–12, 94114–27, 94129–34, 94137, 94139–47, 94151, 94156, 94158–64, 94172, 94177, 94188
- All ZIP codes in San Joaquin County are inside our Service Area: 94514, 95201–13, 95215, 95219–20, 95227, 95230–31, 95234, 95236–37, 95240–42, 95253, 95258, 95267, 95269, 95296–97, 95304, 95320, 95330, 95336–37, 95361, 95366, 95376–78, 95385, 95391, 95632, 95686, 95690
- All ZIP codes in San Mateo county are inside our Service Area: 94002, 94005, 94010–11, 94014–21, 94025–28, 94030, 94037–38, 94044, 94060–66, 94070, 94074, 94080, 94083, 94128, 94303, 94401–04, 94497
- The following ZIP codes in Santa Clara County are inside our Service Area: 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, 95196
- All ZIP codes in Solano County are inside our Service Area: 94510, 94512, 94533–35, 94571, 94585, 94589–92, 95616, 95620, 95625, 95687–88, 95690, 95694, 95696
- The following ZIP codes in Sonoma County are inside our Service Area: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492
- All ZIP codes in Stanislaus County are inside our Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322–23, 95326, 95328–29, 95350–58, 95360–61, 95363, 95367–68, 95380–82, 95385–87, 95397
- The following ZIP codes in Sutter County are inside our Service Area: 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95836–37
- The following ZIP codes in Tulare County are inside our Service Area: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- The following ZIP codes in Yolo County are inside our Service Area: 95605, 95607, 95612, 95616-18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- The following ZIP codes in Yuba County are inside our Service Area: 95692, 95903, 95961

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

- The following ZIP codes in Imperial County are inside our Service Area: 92274–75
- The following ZIP codes in Kern County are inside our Service Area: 93203, 93205-06, 93215–16, 93220, 93222, 93224–26, 93238, 93240–41, 93243, 93249–52, 93263, 93268, 93276, 93280, 93285, 93287, 93301–09, 93311–14, 93380, 93383–90, 93501–02, 93504–05, 93518–19, 93531, 93536, 93560–61, 93581
- The following ZIP codes in Los Angeles County are inside our Service Area: 90001–84, 90086–91, 90093–96, 90099, 90101, 90103, 90189, 90201–02, 90209–13, 90220–24, 90230–33, 90239–42, 90245, 90247–51, 90254–55, 90260–67, 90270, 90272, 90274–75, 90277–78, 90280, 90290–96, 90301–12,

90401–11, 90501–10, 90601–10, 90623, 90630–31, 90637–40, 90650–52, 90660–62, 90670–71, 90701–03, 90706–07, 90710–17, 90723, 90731–34, 90744–49, 90755, 90801–10, 90813–15, 90822, 90831–35, 90840, 90842, 90844, 90846–48, 90853, 90895, 90889, 91001, 91003, 91006–12, 91016–17, 91020–21, 91023–25, 91030–31, 91040–43, 91046, 91066, 91077, 91101–10, 91114–18, 91121, 91123–26, 91129, 91182, 91184–85, 91188–89, 91199, 91201–10, 91214, 91221–22, 91224–26, 91301–11, 91313, 91316, 91321–22, 91324–31, 91333–35, 91337, 91340–46, 91350–57, 91361—62, 91364–65, 91367, 91371–72, 91376, 91380–87, 91390, 91392–96, 91401–13, 91416, 91423, 91426, 91436, 91470, 91482, 91495-96, 91499, 91501–08, 91510, 91521–23, 91526, 91601–12, 91614–18, 91702, 91706, 91709, 91711, 91714–16, 91722–24, 91731–35, 91740–41, 91744–50, 91754–56, 91765–73, 91775–76, 91778, 91780, 91788–93, 91795, 91801–04, 91896, 91899, 93243, 93510, 93532, 93534–36, 93539, 93543–44, 93550–53, 93560, 93563, 93584, 93586, 93590–91, 93599

- All ZIP codes in Orange County are inside our Service Area: 90620–24, 90630–33, 90638, 90680, 90720–21, 90740, 90742–43, 92602–07, 92609–10, 92612, 92614–20, 92623–30, 92637, 92646–63, 92672–79, 92683–85, 92688, 92690–94, 92697–98, 92701–08, 92711–12, 92728, 92735, 92780–82, 92799, 92801–09, 92811–12, 92814–17, 92821–23, 92825, 92831–38, 92840–46, 92850, 92856–57, 92859, 92861–71, 92885–87, 92899
- The following ZIP codes in Riverside County are inside our Service Area: 91752, 92201–03, 92210-11, 92220, 92223, 92230, 92234–36, 92240–41, 92247–48, 92253–55, 92258, 92260–64, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501-09, 92513–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92589–93, 92595–96, 92599, 92860, 92877–83
- The following ZIP codes in San Bernardino County are inside our Service Area: 91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758–59, 91761–64, 91766, 91784–86, 91792, 92252, 92256, 92268, 92277–78, 92284–86, 92305, 92307–08, 92313–18, 92321–22, 92324–26, 92329, 92331, 92333–37, 92339–41, 92344–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–95, 92397, 92399, 92401–08, 92410–15, 92418, 92423–24, 92427, 92880
- The following ZIP codes in San Diego County are inside our Service Area: 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–47, 91950–51, 91962–63, 91976–80, 91987, 92003, 92007–11, 92013–14, 92018–30, 92033, 92037–40, 92046, 92049, 92051–52, 92054–61, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92081–86. 92088, 92091–93, 92096, 92101–24, 92126–32, 92134–40, 92142–43, 92145, 92147, 92149-50, 92152–55, 92158–79, 92182, 92184, 92186-87, 92190–91, 92193, 92195–99
- The following ZIP codes in Ventura County are inside our Service Area: 90265, 91304, 91307, 91311, 91319–20, 91358–62, 91377, 93001–07, 93009–12, 93015–16, 93020–22, 93030–36, 93040–44, 93060–66, 93094, 93099, 93252

For each ZIP code listed for a county, our Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside our Service Area unless that other county is listed above and that ZIP code is also listed for that other county. If you have a question about whether a ZIP code is in our Service Area, please call our Member Service Contact Center.

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

Services: Health care services or items (“health care” includes both physical health care and mental health care) and behavioral health treatment covered under "Behavioral Health Treatment for Pervasive Developmental Disorder or Autism" in the *Membership Agreement and Evidence of Coverage*.

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 for whom we have received applicable Premiums.

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