Disclosure Form Part Two

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

Overview of your coverage

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

Introduction

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

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

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

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Regions in California (the Northern California or Southern California Region), which we call your "Home Region." Refer to *Your Benefits (Disclosure Form Part One)* to learn which California Region is your Home Region. **The coverage information in this *Disclosure Form* applies when you obtain care in the Service Area of your Home Region.** See "Home Region" in the "Definitions" section for the geographic area of your Service Area.

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

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

Also, this *Disclosure Form* describes different benefit plans, for example benefit plans that may include deductibles for specified Services. Everything in this section of the *Disclosure Form* applies to all benefit plans, except as otherwise indicated. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

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

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

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

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

How to Obtain Services

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

- Authorized referrals
- Emergency ambulance Services
- Emergency Services and Care, Post-Stabilization Care, and Out-of-Area Urgent Care
- Hospice care
- Covered Services received outside of your Service Area

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

Emergency Services

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

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

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

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

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

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

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

Urgent Care

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

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

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

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

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

Your ID card

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

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

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

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

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week

- Emergency Services and Care are available at Plan Hospital emergency departments listed in *Your Guidebook* (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for emergency department locations in your area)
- Same-day Urgent Care appointments are available at many locations (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for Urgent Care locations in your area)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services office (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for locations in your area)

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

Your personal Plan Physician

Personal Plan Physicians play an important role in coordinating care, including hospital stays and referrals to specialists. We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology who the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. You can change your personal Plan Physician at any time for any reason. To learn how to select a personal Plan Physician, please call Member Services at **1-800-464-4000** (TTY users call **711**). You can find a directory of our Plan Physicians on our website at **kp.org**.

Getting a Referral

Referrals to Plan Providers

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

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

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

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

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

Standing referrals

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

Medical Group authorization procedure for certain referrals

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

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

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

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

Second Opinions

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

Timely Access to Care

Standards for appointment availability

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

- Urgent care appointment: within 48 hours

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

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

Timely access to telephone assistance

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

Interpreter Services

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

Access to mental health Services and substance use disorder treatment

State law requires disclosure form documents to include the following notice:

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

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

If your health plan does not arrange for you to receive services within these timeframes and within geographic access standards, you can arrange to receive services from any

licensed provider, even if the provider is not in your health plan's network. To be covered by your health plan, your first appointment with the provider must be within 90 calendar days of the date you first asked the plan for the MH/SUD services.

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

How Plan Providers are Paid

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

Your Costs

Cost Share (deductibles, Copayments, and Coinsurance)

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

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

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

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

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

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

Copayments and Coinsurance

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

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

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

Drug Deductible

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

Plan Deductible

If your coverage includes a Plan Deductible, the deductible limits will be specified in *Your Benefits (Disclosure Form Part One)*. Note: The Plan Deductible amount for a High Deductible Health Plan is subject to increase if the U.S. Department of the Treasury changes the required minimum deductible.

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

When the Copayment or Coinsurance for a particular Service is subject to the Plan Deductible you must pay Charges for those Services until you meet the deductible. Refer to the *EOC* for more information about which Services are subject to the Plan Deductible and an explanation of how the deductible works.

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

Plan Out-of-Pocket Maximum

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

Accrual toward deductibles and out-of-pocket maximums

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

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

Payment of Premiums

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

Financial liability

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

Refer to “Completion of Services from Non–Plan Providers in the “Miscellaneous notices” section for more information.

Reimbursement for Services Obtained from a Non-Plan Provider

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

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

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

- ♦ one of our representatives will be happy to assist you if you need help completing our claim form

- If you have paid for Services, you must send us our completed claim form for reimbursement. Please attach any bills and receipts from the Non–Plan Provider
- To request that a Non–Plan Provider be paid for Services, you must send us our completed claim form and include any bills from the Non–Plan Provider. If the Non–Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the Non–Plan Provider for covered Services other than your Cost Share amount, please call Member Services toll free at **1-800-390-3510** for assistance
- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled. For example, we may require documents such as travel documents or verification of your travel or itinerary.

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

Termination of Benefits

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

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

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

Refer to the *EOC* for more information.

Continuation of Membership

Continuation of group coverage

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

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

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

Individual plan

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

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

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

Getting Assistance

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

Member Services

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

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

You can reach Member Services in the following ways:

Call	**1-800-464-4000** (English and more than 150 languages using interpreter services) **1-800-788-0616** (Spanish) **1-800-757-7585** (Chinese dialects) TTY users call **711** 24 hours a day, seven days a week (closed holidays)
Visit	Member Services office at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for addresses)
Write	Member Services office at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for addresses)
Website	**kp.org**

Dispute Resolution and Binding Arbitration

Member Services representatives can help you with unresolved issues at our Plan Facilities or by phone at **1-800-464-4000** (TTY users call **711**). They can also help you file a grievance orally or in writing. You can also submit a grievance electronically at **kp.org**. You must submit your grievance within 180 days of the date of the incident.

Independent medical review is available if you believe that we improperly denied, modified, or delayed Services or payment of Services, and that either (1) our denial was based on a finding that the Services are not Medically Necessary, or (2) for life-threatening or seriously debilitating conditions, the requested treatment was denied as experimental or investigational. Also, if you should file a grievance and you later need help with it because your grievance is an emergency, it hasn't been resolved to your satisfaction, or it's unresolved after 30 days, you may call the California Department of Managed Health Care toll free at **1-888-466-2219** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired for assistance.

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

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

Renewal Provisions

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

Principal Exclusions, Limitations, and Reductions of Benefits

Exclusions

The following are the principal exclusions from coverage. See the *EOC* for the complete list, including details and any exceptions to the exclusions. These exclusions or limitations do not apply to Services that are Medically Necessary to treat mental health conditions or substance use disorders that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the International Classification of Diseases or that are listed in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders.

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

Chiropractic services
This plan does not cover chiropractic services, except as required by law, unless you have coverage for supplemental chiropractic Services as described in an amendment to the *EOC*.

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

Coverage of Approved Clinical Trials does not include the following:

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

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

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

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

This cosmetic services exclusion does not apply to the following:

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

Custodial or domiciliary care
This plan does not cover custodial care, which involves assistance with activities of daily living, including but not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications that are ordinarily self-administered, except as required by law.

This exclusion does not apply to the following:

- Assistance with activities of daily living that requires the regular services of or is regularly provided by trained medical or health professionals (see "Hospice Care," "Home Health Care," "Skilled Nursing Facility Care,"

"Hospital Inpatient Services," "Mental Health Services," and "Substance Using Disorder Treatment" in the "Benefits" section of the *EOC*)

- Assistance with activities of daily living that is provided as part of covered hospice, home health, skilled nursing facility, or inpatient hospital care (see "Hospice Care," "Home Health Care," "Skilled Nursing Facility Care," "Hospital Inpatient Services," "Mental Health Services," and "Substance Using Disorder Treatment" in the "Benefits" section of the *EOC*)
- Custodial care provided in a healthcare facility (see "Hospice Care," "Skilled Nursing Facility Care," "Hospital Inpatient Services," "Mental Health Services," and "Substance Using Disorder Treatment" in the "Benefits" section of the *EOC*)

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

Dietary or nutritional supplements
This plan does not cover dietary or nutritional supplements, except as required by law.

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

Experimental Services or Investigational Services
This plan does not cover Experimental Services or Investigational Services, except as described below, or as required by law.

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

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

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

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

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

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

Qualifications

- You must have a Life-Threatening or Seriously Debilitating condition

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

External, Independent Review Process

If the health plan denies coverage of the recommended or requested therapy and you meet all of the qualifications, the health plan will notify you within five business days of its decision and your opportunity to request external review of the health plan's decision. If your Health Care Provider determines that the proposed service would be significantly less effective if not promptly initiated, you may request expedited review and the experts on the external review panel will render a decision within seven days of your request. If the external review panel recommends that the health plan cover the recommended or requested service, coverage for the services will be subject to the terms and conditions generally applicable to other benefits to which you are entitled.

DMHC's Independent Medical Review ("IMR")

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

Hearing aids

This plan does not cover hearing aids, except as described in the *EOC* under "Hearing Services" in the "Benefits" section, or as required by law.

Non-licensed or non-certified providers

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

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

Personal or comfort items

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

Prescription Drugs / Outpatient Prescription Drugs

This plan does not cover the following Prescription Drugs, except as described in the *EOC* under "Outpatient Pharmacy Services" or "Preventive Services" in the "Benefits" section or as required by law:

- When prescribed for cosmetic services. For purposes of this exclusion, cosmetic means drugs solely prescribed for the purpose of altering or affecting normal structure of the body to improve appearance rather than function

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

Private duty nursing
This plan does not cover private duty nursing in the home, hospital, or long-term care facility, except as required by law.

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

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

Surrogate pregnancy
This plan does not cover testing, services, or supplies for a person who is not covered under the *EOC* for a surrogate pregnancy, except as required by law.

Therapies
This plan does not cover the following physical and occupational therapies, except as described in the *EOC* under "Rehabilitative and Habilitative Services" in the "Benefits" section, or as required by law:

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

Travel and lodging
This plan does not cover transportation, mileage, lodging, meals, and other Member-related travel costs, except for licensed ambulance or psychiatric transport as described in the *EOC* under “Ambulance Services” in the “Benefits” section or as described under “Travel and Lodging for Certain Services” in the ‘How to Obtain Services” section.

Vision care
This plan does not cover vision services, except as described in the *EOC* under “Vision Services for Adult Members” and “Vision Services for Pediatric Members” in the “Benefits” section, or as required by law.

Weight control programs and exercise programs

- This plan does not cover weight control programs and exercise programs, except as described in the *EOC* under “Health Education” in the “Benefits” section, or as required by law.

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 or Psychiatric Emergency Medical Condition, call 911 or go to the nearest emergency department as described under “Emergency Services” in the “How to obtain care” section and we will provide coverage as described in that section.

Reductions

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

Refer to the *EOC* for additional information and other reductions (for example, surrogacy arrangements and workers’ compensation).

To Become a Member

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

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

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

Persons barred from enrolling

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

Miscellaneous Notices

Completion of Services from Non–Plan Providers

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

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

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

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

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

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

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

Drug formulary

The drug formulary includes a list of drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members in your Service Area. Our Pharmacy and Therapeutics Committee, which is primarily comprised of Plan Physicians and pharmacists, selects drugs for the drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature. The drug formulary is updated monthly based on new information or new drugs that become available. To find out which drugs are on the formulary for your plan, please visit our website at **kp.org/formulary**. If you would like to request a copy of the drug formulary for your plan, please call Member Services. Note: The presence of a drug on the drug formulary does not necessarily mean that it will be prescribed for a particular medical condition.

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

Refer to *Your Benefits (Disclosure Form Part One)* to learn if you have coverage for Prescription Drugs.

Privacy practices

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

You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means. You may request confidential communication by completing a confidential communication request form, which is available on **kp.org** under "Request for confidential communications forms." Your request for confidential communication will be valid until you submit a revocation or a new request for confidential communication. If you have questions, please call Member Services.

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

We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

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

Special note about Medicare

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

Fertility preservation Services for iatrogenic infertility (effective July 1, 2025)

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

If you do not need the services urgently, your health plan must offer an appointment for you that is no more than 10 business days for primary care and 15 business days for specialist care from when you requested the services from your health plan. If you

urgently need the services, your health plan must offer you an appointment within 48 hours of your request (if your health plan does not require prior authorization for the appointment) or within 96 hours (if your health plan does require prior authorization).

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

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

Definitions

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

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

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

- The study or investigation is approved or funded, which may include funding through in-kind donations, by one or more of the following:
  - The National Institutes of Health
  - The federal Centers for Disease Control and Prevention
  - The Agency for Healthcare Research and Quality
  - The federal Centers for Medicare and Medicaid Services
  - A cooperative group or center of the National Institutes of Health, the federal Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the federal Centers for Medicare and Medicaid Services, the Department of Defense, or the United States Department of Veterans Affairs
  - A qualified nongovernmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
  - One of the following departments, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary of the United States Department of Health and Human Services determines is comparable to the system of peer review used by the National Institutes of Health and ensures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

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

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

- The treatment is prescribed by a Plan Physician, or is developed by a Plan Provider who is a psychologist
- The treatment is administered by a Plan Provider who is a qualified autism service provider, qualified autism service professional, or qualified autism service paraprofessional, as defined in California Health and Safety Code section 1374.73(c)

Charges: "Charges" means the following:

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

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

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

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

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

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

Drug Deductible: The amount you must pay under the *EOC* in the Accumulation Period for certain drugs, supplies, and supplements before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to *Your Benefits (Disclosure Form Part One)* to learn whether your coverage includes a Drug Deductible, the Services that are subject to the Drug Deductible, and the Drug Deductible amount.

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

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

Emergency Services and Care: Either of the following:

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

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

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

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

Family: A Subscriber and all of their Dependents.

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

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

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. Contributions made to a Health Savings Account by an eligible individual are tax deductible under federal tax law whether or not the individual itemizes deductions. In order to make contributions to a Health Savings Account, you must be covered under a qualified High Deductible Health Plan and meet other tax law eligibility requirements.

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

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

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

Northern California Region Service Area

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

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

- Solano County (whole county): 94503, 94510, 94512, 94533-35, 94571, 94585, 94589-92, 95616, 95618, 95620, 95625, 95687-88, 95690, 95694, 95696
- Sonoma County: 94515, 94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999, 95401-07, 95409, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, 95492
- Stanislaus County (whole county): 95230, 95304, 95307, 95313, 95316, 95319, 95322-23, 95326, 95328-29, 95350-58, 95360-61, 95363, 95367-68, 95380-82, 95385-87, 95397
- Sutter County: 95626, 95645, 95659, 95668, 95674, 95676, 95692, 95836-7
- Tulare County: 93618, 93631, 93646, 93654, 93666, 93673
- Yolo County: 95605, 95607, 95612, 95615-18, 95620, 95645, 95691, 95694-95, 95697-98, 95776, 95798-99
- Yuba County: 95692, 95903, 95961

Southern California Region Service Area

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

- Imperial County: 92274-75
- Kern County: 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380, 93383-90, 93501-02, 93504-05, 93518-19, 93531, 93536, 93560-61, 93581
- Los Angeles County: 90001-84, 90086-89, 90091, 90093-96, 90099, 90134, 90140, 90189, 90201-02, 90205, 90209-13, 90220-24, 90230-32, 90239-42, 90245, 90247-51, 90254-55, 90260, 90262-67, 90270, 90272, 90274-75, 90277-78, 90280, 90290-96, 90301-12, 90401-11, 90501-10, 90601-10, 90623, 90630-31, 90637-40, 90650-52, 90660-62, 90670-71, 90701-03, 90706-07, 90710-17, 90723, 90731-34, 90744-49, 90755, 90801-10, 90813-15, 90822, 90831-33, 90840, 90842, 90844, 90846-48, 90853, 90895, 91001, 91003, 91006-12, 91016-17, 91020-21, 91023-25, 91030-31, 91040-43, 91046, 91066, 91077, 91101-10, 91114-18, 91121, 91123-26, 91129, 91182, 91184-85, 91188-89, 91199, 91201-10, 91214, 91221-22, 91224-26, 91301-11, 91313, 91316, 91321-22, 91324-28, 91330-31, 91333-35, 91337, 91340-46, 91350-57, 91361-62, 91364-65, 91367, 91371-72, 91376, 91380-87, 91390, 91392-96, 91401-13, 91416, 91423, 91426, 91436, 91470, 91482, 91499, 91501-08, 91510, 91521-23, 91601-10, 91614-18, 91702, 91706, 91711, 91714-16, 91722-24, 91731-35, 91740-41, 91744-50, 91754-56, 91759, 91765-73, 91775-76, 91778, 91780, 91788-93, 91801-04, 91896, 91899, 93243, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93560, 93563, 93584, 93586, 93590-91, 93599
- Orange County (whole county): 90620-24, 90630-33, 90638, 90680, 90720-21, 90740, 90742-43, 92602-07, 92609-10, 92612, 92614-20, 92623-30, 92637, 92646-63, 92672-79, 92683-85, 92688, 92690-94, 92697-98, 92701-08, 92711, 92728, 92735, 92780-82, 92799, 92801-09, 92811-12, 92814-17, 92821-23, 92825, 92831-38, 92840-46, 92856-57, 92859, 92861-71, 92885-87, 92899
- Riverside County: 91752, 92028, 92201-03, 92210-11, 92220, 92223, 92230, 92234-36, 92240-41, 92247-48, 92253-55, 92258, 92260-64, 92270, 92274, 92276, 92282, 92320, 92324, 92373, 92399, 92501-09, 92513-14, 92516-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92589-93, 92595-96, 92599, 92860, 92877-83
- San Bernardino County: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91766, 91784-86, 92252, 92256, 92268, 92277-78, 92284-86, 92305, 92307-08, 92313-18, 92321-22, 92324-25, 92329, 92331, 92333-37, 92339-41, 92344-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-95, 92397, 92399, 92401-08, 92410-11, 92413, 92415, 92418, 92423, 92427, 92880
- San Diego County: 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-46, 91950-51, 91962-63, 91976-80, 91987, 92003, 92007-11, 92013-14, 92018-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-61, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-86, 92088, 92091-93, 92096, 92101-24, 92126-32, 92134-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-61, 92163, 92165-79, 92182, 92186-87, 92191-93, 92195-99
- Tulare County: 93238, 93261

- Ventura County: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07, 93009-12, 93015-16, 93020-22, 93030-36, 93040-44, 93060-66, 93094, 93099, 93252

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

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

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

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

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

Life-Threatening: Either or both of the following:

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

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

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

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

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

Member: A Subscriber or Dependent of a Subscriber whose coverage is active.

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

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

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

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

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

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

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

Plan Facility: Any facility listed in the Provider Directory on our website at **kp.org/facilities** for your Service Area. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services at **1-800-464-4000** (TTY users call **711**).

Plan Hospital: Any hospital listed in the Provider Directory on our website at **kp.org/facilities** for your Service Area. In the directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call Member Services at **1-800-464-4000** (TTY users call **711**).

Plan Medical Office: Any medical office listed in the Provider Directory on our website at **kp.org/facilities** for your Service Area. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The directory is updated periodically. The availability of Plan Medical Offices may change. If you have questions, please call Member Services at **1-800-464-4000** (TTY users call **711**).

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

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the Provider Directory on our website at **kp.org/facilities** for your Service Area for locations of Plan Pharmacies. The directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call Member Services at **1-800-464-4000** (TTY users call **711**).

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

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

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

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

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

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

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

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

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

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

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

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

Surrogacy Arrangement: An arrangement in which an individual agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children). The person may be impregnated in any manner including, but not limited to, artificial insemination, intrauterine insemination, in vitro fertilization, or through the surgical implantation of a fertilized egg of another person. For the purposes of the *EOC*, "Surrogacy Arrangements" includes all types of surrogacy arrangements, including traditional surrogacy arrangements and gestational surrogacy arrangements.

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

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