



KAISER PERMANENTE

Kaiser Foundation Health Plan, Inc.
Electronic Documents Policy

This policy document constitutes the explicit, written permission of Kaiser Foundation Health Plan, Inc., (Health Plan) for the Purchaser to use the accompanying Health Plan Enrollment and Member electronic documents under the following conditions:

These electronic documents must be used as provided, without additions, deletions, or other modifications.

These electronic documents are being provided in English. Translation of these documents by any person/organization other than by Health Plan (or certified translation agencies authorized by Health Plan) is prohibited. Please contact your Health Plan account representative to learn which documents are available in other languages.

These electronic documents may be posted to Purchaser Web sites.

Health Plan will provide updated versions of these electronic documents if there are substantive language changes. Purchasers must transfer the updated versions to their sites as soon as reasonably possible, but not later than 30 days after receipt of an updated document.

The Disclosure Form (DF) is subject to change. Health Plan will provide substantive DF language changes electronically to Purchasers. It is the Purchaser's responsibility to ensure that all changes are provided to employees. All electronic DF documents include a footnote containing an original issuance date to ensure accurate tracking.

If you have questions about our Electronic Documents Policy, or questions about a specific request for an electronic document, please contact your account representative for assistance.

Kaiser Foundation Health Plan, Inc.
California Division

DISCLOSURE FORM PART ONE — PRINCIPAL BENEFITS FOR
KAISER PERMANENTE TRADITIONAL PLAN (7/1/11—6/30/12)

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

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

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	\$1,500 per calendar year
For any one Member in a Family of two or more Members	\$1,500 per calendar year
For an entire Family of two or more Members	\$3,000 per calendar year
Deductible	None
Lifetime Maximum	
Services covered under "Transgender Surgery" in the <i>EOC</i>	\$75,000
All other Services	None
Professional Services (Plan Provider office visits)	You Pay
Most primary and specialty care consultations and exams	\$15 per visit
Routine physical maintenance exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling	No charge
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations and exams	\$15 per visit
Physical, occupational, and speech therapy	\$15 per visit
Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	\$15 per procedure
Allergy injections (including allergy serum)	\$5 per visit
Most immunizations (including vaccines)	No charge
Most X-rays and laboratory tests	No charge
Health education:	
Covered individual health education counseling	No charge
Covered health educational programs	No charge
Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	\$100 per admission
Emergency Health Coverage	You Pay
Emergency Department visits	\$100 per visit
Note: This Cost Sharing does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Sharing)	
Ambulance Services	You Pay
Ambulance Services	No charge

continued

Prescription Drug Coverage		You Pay
Most covered outpatient items in accord with our drug formulary guidelines:		
Generic items from a Plan Pharmacy		\$5 for up to a 30-day supply, \$10 for a 31- to 60-day supply, or \$15 for a 61- to 100-day supply
Generic refills from our mail-order service.....		\$5 for up to a 30-day supply or \$10 for a 31- to 100-day supply
Brand-name items from a Plan Pharmacy.....		\$15 for up to a 30-day supply, \$30 for a 31- to 60-day supply, or \$45 for a 61- to 100-day supply
Brand-name refills from our mail-order service.....		\$15 for up to a 30-day supply or \$30 for a 31- to 100-day supply
Durable Medical Equipment		You Pay
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines		
		No charge
Mental Health Services		You Pay
Inpatient psychiatric hospitalization.....		\$100 per admission
Outpatient mental health evaluation and treatment		\$15 per individual visit \$7 per group visit
Chemical Dependency Services		You Pay
Inpatient detoxification		\$100 per admission
Individual outpatient chemical dependency consultations and treatment		\$15 per visit
Group outpatient chemical dependency treatment		\$5 per visit
Home Health Services		You Pay
Home health care (up to 100 visits per calendar year)		No charge
Other		You Pay
Hearing aid(s) every 36 months.....		Amount in excess of \$2,500 Allowance per aid
Skilled nursing facility care (up to 100 days per benefit period).....		No charge
One treatment cycle per lifetime related to covered conception by artificial means.....		50% Coinsurance
Hospice care.....		No charge

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

HEALTH CARE REFORM CHANGES

Because of the recent health care reform law (formally known as the Patient Protection and Affordable Care Act or "PPACA"), we are updating some information you may see in this booklet. These changes are for Plan years beginning on or after September 23, 2010. You'll find more details in your *Evidence of Coverage* or *Certificate of Insurance*.

Grandfathered coverage

If your group's coverage is a "grandfathered health plan" under PPACA, certain mandates may not apply, as described below. To find out whether your coverage is grandfathered, or for other questions about grandfathered coverage, please ask your group.

Preventive services

Please refer to the "Benefit Highlights" section for the cost sharing that applies for preventive services. If your coverage is not a "grandfathered health plan" under PPACA, or if your group has purchased the preventive package for non-grandfathered coverage, there will be no copayments, coinsurance, or deductibles for any of the preventive services that are specified in the health care reform law, or that are mandated by state law.

Coverage for adult children

Under new federal law, dependent children may stay on their family's plan until they turn 26. If you have children who will be younger than 26 at the start of the next Plan year, you will be able to enroll them, subject to your group's eligibility rules, even if they previously lost or were unable to get coverage because of their age.

Removal of annual or lifetime limits

We're removing all lifetime and annual dollar limits on essential health benefits. Members who exceeded these limits before will now be covered for these services, going forward.

More information

For more information about these or other benefit changes, please contact our Member Service Call Center, weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays), toll free at **1-800-464-4000** or **1-800-777-1370** (TTY for the deaf, hard of hearing, or speech impaired).

For more information on health care reform and how we're responding to it, please visit kp.org/reform.

KAISER PERMANENTE

DISCLOSURE FORM PART TWO

TRADITIONAL PLAN AND DEDUCTIBLE PLAN

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

HELP IN YOUR LANGUAGE

Interpreters are available 24 hours a day, seven days a week, at no cost to you. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may be able to get materials written in your language.

For more information, call our Member Service Call Center at **1-800-464-4000** or **1-800-777-1370** (TTY) weekdays from 7 a.m. to 7 p.m., and weekends from 7 a.m. to 3 p.m.

AYUDA EN SU PROPIO IDIOMA

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

我們用您的語言為您提供幫助

我們每週七天，每天24小時為您提供免費翻譯服務。我們也會為您、您的家人、及朋友提供利用我們的設施及服務所需的任何協助。此外你還可以索取以您的母語編寫的資料。查詢詳情，請於週一至週五上午7時至下午7時、週末上午7時至下午3時、致電**1-800-757-7585**或**1-800-777-1370**(TTY專線)與我們的會員服務電話中心聯絡。

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Service Areas in California (the Northern California or Southern California Region), which we call your "Home Region." Please refer to *Your Benefits (Disclosure Form Part One)* to learn which California Region is your Home Region. This *Disclosure Form* describes your coverage in your Home Region.

Please see *Your Benefits (Disclosure Form Part One)* for a summary of Deductibles, Copayments, and Coinsurance. If you have questions about benefits, please call our Member Service Call Center toll free at **1-800-464-4000** or refer to the *Evidence of Coverage*.

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

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

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

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

HOW TO OBTAIN CARE

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

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

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

Emergency Care and Post-Stabilization Care from Non-Plan Providers

Emergency Care. If you have an Emergency Medical Condition, call **911** or go to the nearest hospital. When you have an Emergency Medical Condition, we cover Emergency Care anywhere in the world.

An Emergency Medical Condition is any of the following: (1) a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs, (2) active labor when there isn't enough time for safe transfer to a Plan hospital (or designated hospital) before delivery, or if transfer poses a threat to your (or your unborn child's) health and safety, or (3) a mental disorder that manifests itself by acute symptoms of sufficient severity such that either you are an immediate danger to yourself or others, or you are not immediately able to provide for, or use, food, shelter, or clothing, due to the mental disorder.

Note: For ease and continuity of care, we encourage you to go to a Plan Hospital Emergency Department listed in *Your Guidebook* if you are inside your Home Region's Service Area, but only if it is reasonable to do so, considering your condition or symptoms.

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

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

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

Out-of-Area Urgent Care from Non-Plan Providers

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

- You receive the Services from Non-Plan Providers while you are temporarily outside your Home Region's Service Area

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

Your ID card

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

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

Interpreter Services

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

PLAN FACILITIES AND YOUR GUIDEBOOK TO KAISER PERMANENTE SERVICES (YOUR GUIDEBOOK)

At most of our Plan Facilities, you can usually receive all the covered Services you need, including Emergency Care, Urgent Care, specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you. For facility locations, please refer to the enclosed facility listing or call our Member

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

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Care is available at Plan Hospital Emergency Departments listed in *Your Guidebook* (please refer to *Your Guidebook* for Emergency Department locations in your area)
- Same day Urgent Care appointments are available at many locations (please refer to *Your Guidebook* for Urgent Care locations in your area)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (refer to *Your Guidebook* for locations in your area)

Plan Medical Offices and Plan Hospitals for your area are listed in *Your Guidebook*. *Your Guidebook* describes the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. *Your Guidebook* also explains how to use our Services and make appointments, lists hours of operations, and includes a detailed telephone directory for appointments and advice. *Your Guidebook* provides other important information, such as preventive care guidelines and your Member rights and responsibilities.

Your Guidebook is subject to change and periodically updated. We will mail you *Your Guidebook* after you've enrolled. If you do not receive a copy or need another copy, call our Member Service Call Center toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**), weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays). You can also download a copy from our website at **kp.org**.

YOUR PERSONAL PLAN PHYSICIAN

Personal Plan Physicians play an important role in coordinating care, including hospital stays and referrals to specialists. We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology who the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. You can change your personal Plan Physician for any reason. To learn how to select a personal Plan Physician, please call our Member Service Call Center toll free at **1-800-464-4000**. You can find a directory of our Plan Physicians on our website at kp.org. For the current list of physicians that are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook*.

GETTING A REFERRAL

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, urology, and dermatology. However, you do not need a referral to receive care from any of the following:

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

Medical Group authorization procedure for certain referrals

The following Services require prior authorization by the Medical Group for the Services to be covered

(prior authorization means that the Medical Group must approve the Services in advance for the Services to be covered):

- **Durable medical equipment.** If your Plan Physician prescribes durable medical equipment, he or she will submit a written referral to the Plan Hospital's durable medical equipment coordinator, who will authorize the durable medical equipment if he or she determines that your durable medical equipment coverage includes the item and that the item is listed on our formulary for your condition. If the item doesn't appear to meet our durable medical equipment formulary guidelines, then the durable medical equipment coordinator will contact the Plan Physician for additional information. If the durable medical equipment request still doesn't appear to meet our durable medical equipment formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our durable medical equipment formulary, please refer to the *Evidence of Coverage*
- **Ostomy and urological supplies.** If your Plan Physician prescribes ostomy or urological supplies, he or she will submit a written referral to the Plan Hospital's designated coordinator, who will authorize the item if he or she determines that it is covered and the item is listed on our soft goods formulary for your condition. If the item doesn't appear to meet our soft goods formulary guidelines, then the coordinator will contact the Plan Physician for additional information. If the request still doesn't appear to meet our soft goods formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our soft goods formulary, please refer to the *Evidence of Coverage*

- **Services not available from Plan Providers.**

If your Plan Physician decides that you require covered Services not available from Plan Providers, he or she will recommend to the Medical Group that you be referred to a Non-Plan Provider inside or outside your Home Region's Service Area. The appropriate Medical Group designee will authorize the Services if he or she determines that they are Medically Necessary and are not available from a Plan Provider. Referrals to Non-Plan Physicians will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your Plan Physician what Services have been authorized

- **Transplants.** If your Plan Physician makes a written referral for a transplant, the Medical Group's regional transplant advisory committee or board (if one exists) will authorize the Services if it determines that they are Medically Necessary. In cases where no transplant committee or board exists, the Medical Group will refer you to physician(s) at a transplant center, and the Medical Group will authorize the Services if the transplant center's physician(s) determine that they are Medically Necessary.

Note: A Plan Physician may provide or authorize a corneal transplant without using this Medical Group transplant authorization procedure

Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals. This description is only a brief summary of the authorization procedure. For more information and other Services that are subject to an authorization procedure, please refer to the *Evidence of Coverage* or call our Member Service Call Center toll free at **1-800-464-4000**.

SECOND OPINIONS

If you request a second opinion, it will be provided to you when Medically Necessary by an appropriately qualified medical professional. Either you can ask your personal Plan Physician to help you arrange

for a second medical opinion, or you can make an appointment with another Plan Physician. For more information, please refer to the *Evidence of Coverage*.

HOW PLAN PROVIDERS ARE PAID

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital care for Members, please ask your personal Plan Physician or call our Member Service Call Center toll free at **1-800-464-4000**.

YOUR COSTS

Cost Sharing (Deductibles, Copayments, and Coinsurance)

When you receive covered Services, you must pay your Cost Sharing amount as described in the *Evidence of Coverage* at the time you receive the Services.

For items ordered in advance, you may have to pay the Cost Sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Sharing before the item is ordered.

Note: In some cases, we may agree to bill you for your Cost Sharing amount

Copayments and Coinsurance

A summary of Copayments and Coinsurance is listed in *Your Benefits (Disclosure Form Part One)*. Please refer to the "Benefits and Cost Sharing" section of the *Evidence of Coverage* for the complete list of Copayments and Coinsurance.

Deductibles

If your coverage includes Deductibles, you must pay Charges for certain covered Services subject to the Deductible until you meet the Deductible each

calendar year. If you are a Member in a Family of two or more Members, you reach the Deductible either when you meet the Deductible for any one Member, or when your Family reaches the Family Deductible. Each other member in your Family must continue to pay Charges during the calendar year until either he or she reaches the Deductible for any one Member in a Family of two or more Members, or your Family reaches the Family Deductible.

After you meet the Deductible and for the remainder of that calendar year, you pay the applicable Copayment or Coinsurance subject to the annual out-of-pocket maximum. The only payments that count toward a Deductible are those you make for covered Services that are subject to the Deductible, but only if the Service would otherwise be covered. When you pay a Deductible amount for a Service, we will give you a receipt. We will also send you a statement summarizing the amounts you have paid toward reaching your Deductible and the annual out-of-pocket maximum. You can also obtain a copy of this statement from our Deductible Products Service Team at **1-800-390-3507**. Please refer to *Your Benefits (Disclosure Form Part One)* to learn if your coverage is subject to a Deductible and the amount of the Deductible. Please refer to the *Evidence of Coverage*.

Annual out-of-pocket maximum

There is a limit to the total amount of Cost Sharing you must pay in a calendar year for certain Services you receive in the same calendar year, which are listed in the *Evidence of Coverage*. The limit amounts are specified in *Your Benefits (Disclosure Form Part One)*. If you are a Member in a Family of two or more Members, you reach the annual out-of-pocket maximum either when you meet the maximum for any one Member, or when your Family reaches the Family maximum. Please refer to the *Evidence of Coverage* for more information about annual out-of-pocket maximums.

If you enroll in a Deductible Plan, we will send you a monthly statement of the amounts you have paid, including the amount you have paid toward reaching your annual out-of-pocket maximum. If you are not enrolled in a Deductible Plan, ask for and keep the receipt when you pay for one of the Services listed in the *Evidence of Coverage* that count toward reaching the annual out-of-pocket maximum. When the receipts add up to the annual out-of-pocket maximum, please call our Member Service Call Center toll free at **1-800-464-4000** to find out where to turn in your receipts. When you turn them in, we will give you a document stating that you do not have to pay any more Cost Sharing for the specified Services through the end of the calendar year.

Payment of Premiums

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

REIMBURSEMENT FOR EMERGENCY, POST-STABILIZATION, OR OUT-OF-AREA URGENT CARE

If you receive Emergency Care, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non-Plan Provider, you must pay for the Services unless the Non-Plan Provider agrees to bill us. If you want us to pay for the Services you must file a claim. We will reduce any payment we make to you or the Non-Plan Provider by applicable Cost Sharing.

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

- As soon as possible, request our claim form by calling our Member Service Call Center toll free at **1-800-464-4000** or **1-800-390-3510** (TTY users call **1-800-777-1370**). One of our representatives will be happy to assist you if you need help completing our claim form
- If you have paid for Services, you must send us our completed claim form for reimbursement. Please attach any bills and receipts from the Non-Plan Provider
- To request that a Non-Plan Provider be paid for Services, you must send us our completed claim form and include any bills from the Non-Plan Provider. If the Non-Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the Non-Plan Provider for covered Services other than your Cost Sharing amount, please call our Member Service toll free at **1-800-390-3510** for assistance
- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled. For example, we may require documents such as travel documents or original travel tickets to validate your claim

Please refer to the *Evidence of Coverage* 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 as described in the *Evidence of Coverage*
- You commit one of the following acts, we may terminate your membership immediately by sending written notice to the Subscriber, termination will be effective on the date we send the notice, and you will not be allowed to enroll in Health Plan in the future:
 - your behavior threatens the safety of Kaiser Permanente personnel or of any person or property at a Plan Facility
 - you commit theft from Health Plan, from a Plan Provider, or at a Plan Facility
 - you intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider
- Your group fails to pay Premiums for your Family (or if your Family fails to pay Premiums for Cal-COBRA coverage for your Family)

Please refer to the *Evidence of Coverage* for more information.

CONTINUATION OF MEMBERSHIP

Continuation of group coverage

You may be able to continue your group coverage for a limited time after you would otherwise lose eligibility, if required by law, under COBRA or Cal-COBRA. Please refer to the *Evidence of Coverage* 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. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

Note: Medical history does not impact premiums or eligibility for our individual plan described under “Converting from group membership to an individual plan” in this section. 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.

Converting from group membership to an individual plan

You may be eligible to convert to our nongroup Individual–Conversion Plan if you no longer meet the eligibility requirements described in the *Evidence of Coverage*, or if you enroll in COBRA, Cal-COBRA, or USERRA continuation coverage and then lose eligibility for that coverage. We must receive your enrollment application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

For information about converting your membership or about other individual plans, please refer to the *Evidence of Coverage*, or call our Member Service Call Center toll free at **1-800-464-4000**.

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

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Call Center representatives are available to assist you weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays) toll free at **1-800-464-4000** (TTY users call **1-800-777-1370**). For your convenience, you can also contact us through our website at **kp.org**.

Member Service representatives at our Plan Facilities and Member Service Call Center can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace your ID card. These representatives can also help you if you need to file a claim.

DISPUTE RESOLUTION AND BINDING ARBITRATION

Member Service representatives at our Plan Facilities or Member Service Call Center can help you with

unresolved issues. They can also help you file a grievance orally or in writing. You can also submit a grievance electronically at [kp.org](https://www.kp.org). You must submit your grievance within 180 days of the date of the incident.

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

Except for Small Claims Court cases and, if your group must comply with Employee Retirement Income Security Act (ERISA), certain benefit-related disputes, 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 were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, Services, regardless of legal theory. Both sides give up all rights to a jury or court trial, and both sides are responsible for certain costs associated with binding arbitration.

This is a brief summary of dispute resolution options. Please refer to the *Evidence of Coverage* 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 *Evidence of Coverage* for the complete list, including details and any exceptions to the exclusions. Also, additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the *Evidence of Coverage*.

- Care in a licensed intermediate care facility, except for covered hospice care
- Chiropractic Services, unless otherwise stated in the *Evidence of Coverage*
- Artificial insemination, unless otherwise stated in the *Evidence of Coverage*, and conception by artificial means
- Cosmetic Services, except for Services covered under "Reconstructive Surgery" and "Prosthetic and Orthotic Devices" in the *Evidence of Coverage*
- Custodial care, except for covered hospice care
- Dental care and dental X-rays
- Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies
- Experimental or investigational Services, except as required by law for certain cancer clinical trials. You can request an independent medical review if you disagree with our decision to deny treatment because it is experimental or investigational (please refer to the *Evidence of*

- Coverage for details about independent medical review and other dispute resolution options)
- Eyeglasses, contact lenses, and contact lens eye examinations, unless otherwise stated in the *Evidence of Coverage*
 - Services related to eye surgery or orthokeratologic Services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism
 - Hearing aids, unless otherwise stated in the *Evidence of Coverage*
 - Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food
 - Physical examinations related to employment, insurance, licensing, court orders, parole, or probation, unless a Plan Physician determines that the Services are Medically Necessary
 - Routine foot care Services that are not Medically Necessary
 - Services not approved by the federal Food and Drug Administration (FDA) that by law require FDA approval in order to be sold in the U.S., except for certain experimental or investigational Services, and as required by law for certain cancer clinical trials
 - Services related to conception, pregnancy, or delivery in connection with a surrogacy arrangement, except for otherwise-covered Services provided to a Member who is a surrogate
 - Services related to the diagnosis and treatment of infertility, unless otherwise stated in the *Evidence of Coverage*
 - Services related to a noncovered Service, except for Services we would otherwise cover to treat complications of the noncovered Service
 - Speech therapy Services to treat social, behavioral, or cognitive delays in speech or language development, unless Medically Necessary

- Transgender surgery, unless otherwise stated in the *Evidence of Coverage*
- Travel and lodging expenses
- Treatment of hair loss or growth

Limitations

We will do our best to provide or arrange for our Members' health care needs 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 extreme circumstances, if you have an Emergency Medical Condition, go to the nearest hospital as described under "Emergency Care and Post-Stabilization Care from Non-Plan Providers" in the "How to obtain care" section and we will provide coverage as described in that section.

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

Reductions

If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered Services, you must pay us Charges for those Services, except that the amount you must pay will not exceed the maximum amount allowed under California Civil Code Section 3040.

Note: This "Reductions" section does not affect your obligation to pay Cost Sharing for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph. Alternatively, we may file a subrogation claim on our own behalf against the third party. In addition to these third party liability claims by Kaiser Permanente, the contracts between Kaiser Permanente and some providers may

allow these providers to recover all or a portion of the difference between the fees paid by Kaiser Permanente and the fees the provider charges to the general public for the Services you received.

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

TO BECOME A MEMBER

We look forward to welcoming you as a Kaiser Permanente Member. If you are eligible to enroll, simply return a completed enrollment application to your group. Be sure to ask your group for your group (purchaser) number and the date when your coverage becomes effective. You can begin using our Services on your effective date of coverage. Again, if you have any questions about Kaiser Permanente, please call our Member Service Call Center toll free at **1-800-464-4000** or you can refer to the *Evidence of Coverage* for details about eligibility requirements.

MISCELLANEOUS NOTICES

Completion of Services from Non-Plan Providers

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

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

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

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends
- Serious Chronic Conditions. We may cover these Services until the earlier of (1) 12 months from your membership effective date if you are a new Member; (2) 12 months from the termination date of the terminated provider; or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non-Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
 - it persists without full cure
 - it worsens over an extended period of time
 - it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Care for children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the child's membership effective date if the child is a new Member; (2) 12 months from the termination date of the terminated provider; or (3) the child's third birthday

- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your membership effective date if you are a new Member or within 180 days of the termination date of the terminated provider

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

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

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

For more information about this provision or to request the Services or a copy of our "Completion of Covered Services" policy, please call our Member Service Call Center.

Drug formulary

Our drug formulary includes the list of drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members in your Home Region's Service Area. Our Pharmacy and Therapeutics Committee, which is primarily comprised of Plan Physicians, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature. The Pharmacy and Therapeutics Committee meets quarterly to consider additions and deletions based on new information or drugs that become available. If you would like to request a copy of our drug formulary, please call our Member Service Call Center.

Note: The presence of a drug on our drug formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition.

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

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

Health Insurance Counseling and Advocacy Program (HICAP)

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

Privacy practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information. Protected health information is health information that includes your name, Social Security number, or other information that reveals who you are. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information.

We may use or disclose your protected health information for treatment, payment, and health care operations purposes, including health research and measuring the quality of care and Services. We are sometimes required by law to give protected health information to government agencies or in judicial actions. In addition, Member-identifiable medical 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* describing our policies and procedures for preserving the confidentiality of medical records and other

protected health information is available and will be furnished to you upon request. To request a copy, please call our Member Service Call Center toll free at 1-800-464-4000. You can also find the notice at your local Plan Facility or on our website at kp.org.

Special note about Medicare

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

DEFINITIONS

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

Charges: Charges means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of the Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente

pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)

- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts Cost Sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract Cost Sharing

Clinically Stable: You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

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

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

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

Deductible: The amount you must pay in a calendar year for certain Services before we will cover those Services at the Copayment or Coinsurance in that calendar year. Any Deductible amounts are listed in *Your Benefits (Disclosure Form Part One)*.

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

Emergency Care:

- Evaluation by a physician (or other appropriate personnel under the supervision of a physician to the extent provided by law) to determine whether you have an Emergency Medical Condition
- Medically Necessary Services required to make you Clinically Stable within the capabilities of the facility
- Emergency ambulance Services covered under "Ambulance Services" in the *Evidence of Coverage*

Emergency Medical Condition: Either: (1) a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs, (2) active labor when there isn't enough time for safe transfer to a Plan hospital (or designated hospital) before delivery, or if transfer poses a threat to your (or your unborn child's) health and safety, or (3) a mental disorder that manifests itself by acute symptoms of sufficient severity such that either you are an immediate danger to yourself or others, or you are not immediately able to provide for, or use, food, shelter, or clothing, due to the mental disorder.

Evidence of Coverage: The *Evidence of Coverage* document describes the health care coverage under Health Plan's *Agreement* with your Group.

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

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

Home Region: Health Plan's Northern California Region or Southern California Region where you are enrolled under the *Group Agreement* between Kaiser Foundation Health Plan, Inc., and your group.

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

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

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

Medicare: A federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). In this *Disclosure Form*, Members who are "eligible for" Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who are "entitled to" or "have" Medicare Part A or B are those who have been granted Medicare Part A or B coverage.

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

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

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

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

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen

complication of an existing condition (including pregnancy) if all of the following are true:

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

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

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

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

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

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

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

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that this condition is Clinically Stable.

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

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

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

Service Area: For Members enrolled in the **Northern California Region**, the following counties are entirely

inside our Northern California Region Service Area: Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus. Portions of the following counties are also inside our Northern California Region Service Area, as indicated by the ZIP codes below for each county:

- **Amador:** 95640, 95669
- **El Dorado:** 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- **Fresno:** 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, 93741, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–80, 93784, 93786, 93790–94, 93844, 93888
- **Kings:** 93230, 93232, 93242, 93631, 93656
- **Madera:** 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- **Mariposa:** 93601, 93623, 93653
- **Napa:** 94503, 94508, 94515, 94558–59, 94562, 94567*, 94573–74, 94576, 94581, 94589–90, 94599, 95476
- **Placer:** 95602–04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95692, 95703, 95722, 95736, 95746–47, 95765
- **Santa Clara:** 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
- **Sonoma:** 94515, 94922–23, 94927–28, 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

- **Sutter:** 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95836–37
- **Tulare:** 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- **Yolo:** 95605, 95607, 95612, 95616–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- **Yuba:** 95692, 95903, 95961

*Exception: Knoxville is not in the Northern California Region Service Area.

For Members enrolled in the **Southern California Region**, Orange County is entirely inside our Southern California Region Service Area. Portions of the following counties are also inside our Southern California Region Service Area, as indicated by the ZIP codes below for each county:

- **Imperial:** 92274–75
- **Kern:** 93203, 93205–06, 93215–16, 93220, 93222, 93224–26, 93238, 93240–41, 93243, 93250–52, 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:** 90001–84, 90086–91, 90093–96, 90101, 90103, 90189, 90201–02, 90209–13, 90220–24, 90230–33, 90239–42, 90245, 90247–51, 90254–55, 90260–67, 90270, 90272, 90274–75, 90277–78, 90280, 90290–96, 90301–12, 90401–11, 90501–10, 90601–10, 90623, 90630–31, 90637–40, 90650–52, 90660–62, 90670–71, 90701–03, 90706–07, 90710–17, 90723, 90731–34, 90744–49, 90755, 90801–10, 90813–15, 90822, 90831–35, 90840, 90842, 90844, 90846–48, 90853, 90895, 91001, 91003, 91006–12, 91016–17, 91020–21, 91023–25, 91030–31, 91040–43, 91046, 91066, 91077, 91101–10, 91114–18, 91121, 91123–26, 91129, 91182, 91184–85, 91188–89, 91199, 91201–10, 91214, 91221–22, 91224–26, 91301–11, 91313, 91316, 91321–22, 91324–31, 91333–35, 91337, 91340–46, 91350–57, 91361–62, 91364–65, 91367, 91371–72, 91376, 91380–81, 91383–87, 91390, 91392–96, 91401–13, 91416, 91423, 91426, 91436, 91470, 91482, 91495–96, 91499, 91501–08, 91510, 91521–23, 91601–12, 91614–18, 91702, 91706, 91709, 91711, 91714–16, 91722–24, 91731–35, 91740–41, 91744–50, 91754–56, 91759, 91765–73, 91775–76, 91778, 91780, 91788–93, 91795, 91801–04, 91896, 93243, 93510, 93532, 93534–36, 93539, 93543–44, 93550–53, 93560, 93563, 93584, 93586, 93590–91, 93599
- **Riverside:** 91752, 92201–03, 92210–11, 92220, 92223, 92230, 92234–36, 92240–41, 92247–48, 92253–55, 92258, 92260–64, 92270, 92274, 92276, 92282, 92292, 92320, 92324, 92373, 92399, 92501–09, 92513–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92589–93, 92595–96, 92599, 92860, 92877–83
- **San Bernardino:** 91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758, 91761–64, 91766, 91784–86, 91792, 92252, 92256, 92268, 92277–78, 92284–86, 92305, 92307–08, 92313–18, 92321–22, 92324–26, 92329, 92331, 92333–37, 92339–41, 92344–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–95, 92397, 92399, 92401–08, 92410–15, 92418, 92423–24, 92427, 92880
- **San Diego:** 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–47, 91950–51, 91962–63, 91976–80, 91987, 92007–11, 92013–14, 92018–30, 92033, 92037–40, 92046, 92049, 92051–52, 92054–58, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92081–85, 92090–93, 92096, 92101–24, 92126–32, 92134–40, 92142–43, 92145, 92147, 92149–50, 92152–55, 92158–79, 92182, 92184, 92186–87, 92190–99
- **Ventura:** 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

A ZIP code is considered to be inside our Service Area only if the county associated with that ZIP code in the list above is inside our Service Area. Since a ZIP code can span more than one county, it is possible for your ZIP code to be listed above, but you do not live inside our Service Area because the county you live in is not part of our Service Area.

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

Services: Health care services or items.

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

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

KAISER PERMANENTE

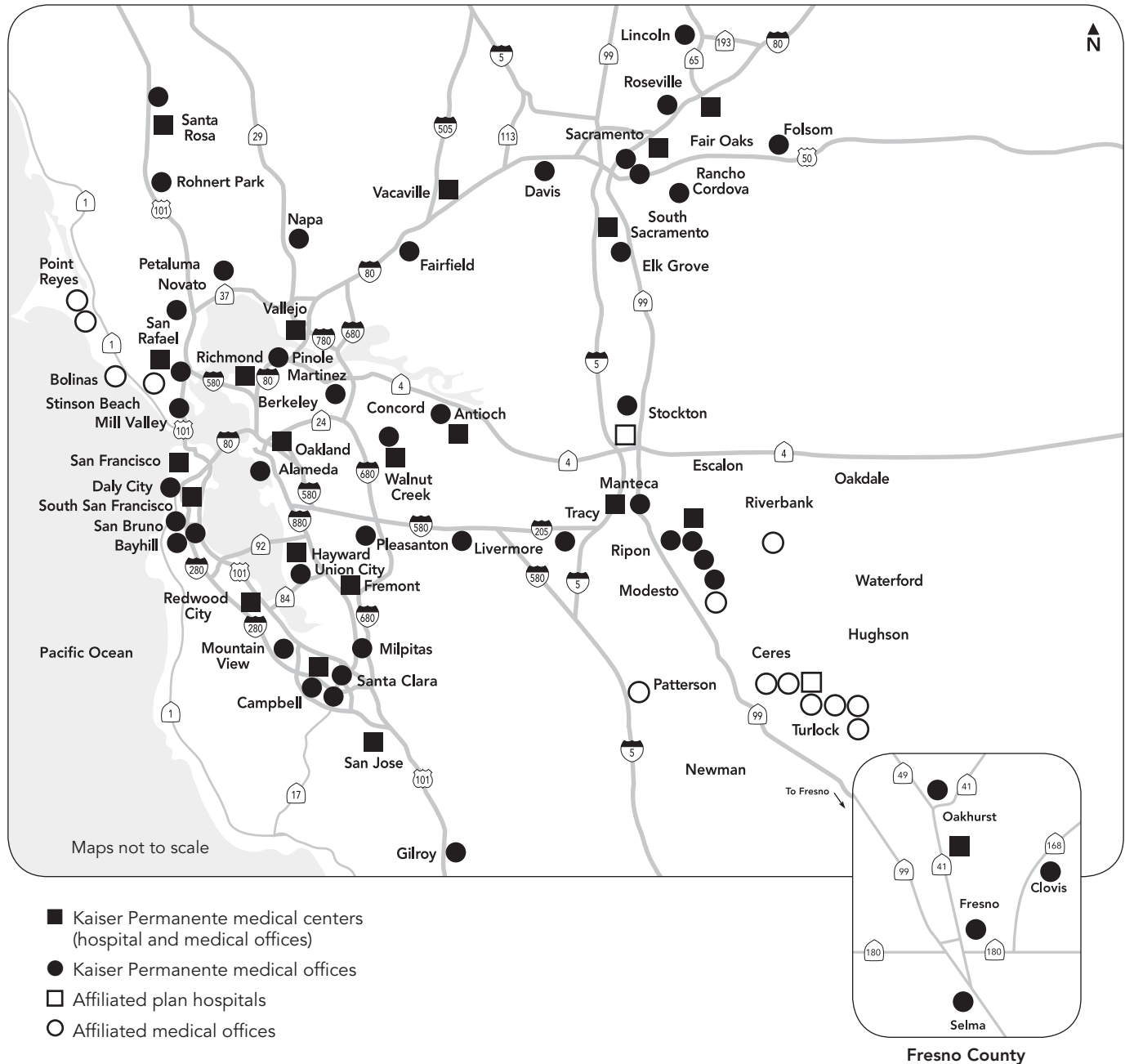
LOCATIONS

With medical offices and hospitals close to where you live, Kaiser Permanente is making California a healthier place to be. And by applying environmentally friendly building practices to current and future facilities, we're committed to keeping it that way for many generations to come.

When you join Kaiser Permanente in California, you're enrolled in either our Northern California or Southern California Region. When visiting the other California region, you can receive care as a visiting member.

NORTHERN CALIFORNIA

The following information can help you find Kaiser Permanente and affiliated facilities in your community.



CITY	FACILITY	ADDRESS
Alameda	● Alameda Medical Offices	2417 Central Ave.
Antioch	■ Antioch Medical Center	4501 Sand Creek Road
	● Delta Fair Medical Offices	3400 Delta Fair Blvd.
Bolinas	○ Bolinas Family Practice	88 Mesa Road
Campbell	● Campbell Medical Offices	200 E. Hacienda Ave. 220 E. Hacienda Ave.
Clovis	● Clovis Medical Offices	2071 E. Herndon Ave.
Daly City	● Daly City Medical Offices	395 Hickey Blvd.
Davis	● Davis Medical Offices	1955 Cowell Blvd.
Elk Grove	● Elk Grove Medical Offices	9201 Big Horn Blvd.
Fairfield	● Fairfield Medical Offices	1550 Gateway Blvd.
Folsom	● Folsom Medical Offices	2155 Iron Point Road
Fremont	■ Fremont Medical Center	39400 Paseo Padre Pkwy.
Fresno	■ Fresno Medical Center	7300 N. Fresno St.
	● First Street Medical Offices	4785 N. First St.
Gilroy	● Gilroy Medical Offices	7520 Arroyo Circle
Hayward	■ Hayward Medical Center	27400 Hesperian Blvd.
Lincoln	● Lincoln Medical Offices	1900 Dresden Drive
Livermore	● Livermore Medical Offices	3000 Las Positas Road
Manteca	■ Manteca Medical Center	1777 W. Yosemite Ave.
	● Manteca Medical Offices	1721 W. Yosemite Ave.
Martinez	● Martinez Medical Offices	200 Muir Road
Mill Valley	● Mill Valley Medical Offices	750 Redwood Hwy.
Milpitas	● Milpitas Medical Offices	770 E. Calaveras Blvd.
Modesto	■ Modesto Medical Center	4601 Dale Road
	● Bangs Avenue Medical Offices	4125 Bangs Ave.
	● Dale Road Medical Offices	3800 Dale Road
	● Modesto Medical Offices	4601 Dale Road
	● Standiford Avenue Medical Offices	1320 Standiford Ave.
	○ Cornerstone Family Practice Medical Group	1444 Florida Ave.
	○ Family Health Care Medical Group	1320 Celeste Drive

- Kaiser Permanente medical centers (hospital and medical offices)
- Kaiser Permanente medical offices
- Affiliated plan hospitals
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Kaiser Permanente medical center locations are in bold and shaded.

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CITY	FACILITY	ADDRESS
Mountain View	● Mountain View Medical Offices	555 Castro St. 565 Castro St.
Napa	● Napa Medical Offices	3285 Claremont Way
Novato	● Novato Medical Offices	97 San Marin Drive
Oakhurst	● Oakhurst Medical Offices	40595 Westlake Drive
Oakland	■ Oakland Medical Center	280 W. MacArthur Blvd.
Patterson	○ First Care Medical Center	101 N. 3rd St.
Petaluma	● Petaluma Medical Offices	3900 Lakeville Hwy.
Pinole	● Pinole Medical Offices	1301 Pinole Valley Road
Pleasanton	● Pleasanton Medical Offices	7601 Stoneridge Drive
Point Reyes Station	○ Point Reyes Medical Clinic	3 Sixth St.
	○ West Marin Medical Center	11150 State Route 1
Rancho Cordova	● Rancho Cordova Medical Offices	10725 International Drive
Redwood City	■ Redwood City Medical Center	1150 Veterans Blvd.
Richmond	■ Richmond Medical Center	901 Nevin Ave.
Rohnert Park	● Rohnert Park Medical Offices	5900 State Farm Drive
Roseville	■ Roseville Medical Center	1600 Eureka Road
	● Roseville Medical Offices – Riverside	1001 Riverside Ave.
Sacramento	■ Sacramento Medical Center	2025 Morse Ave.
	■ South Sacramento Medical Center	6600 Bruceville Road
	● Fair Oaks Boulevard Medical Offices	2345 Fair Oaks Blvd.
San Bruno	● Point West Medical Offices	1650 Response Road
	● Bayhill Medical Offices	801 Traeger Ave. 851 Traeger Ave.
	● San Bruno Medical Offices	901 El Camino Real
	● Sneath Lane Medical Offices	1001 Sneath Lane
San Francisco	■ San Francisco Medical Center	2425 Geary Blvd.
San Jose	■ San Jose Medical Center	250 Hospital Pkwy.
San Rafael	■ San Rafael Medical Center	99 Montecillo Road
	● Downtown San Rafael Medical Offices – 3rd Street	1033 3rd St.

CITY	FACILITY	ADDRESS
Santa Clara	■ Santa Clara Medical Center	700 Lawrence Expwy.
	● Santa Clara Kaiser Drive Medical Offices	2885 Kaiser Drive
	● Santa Clara Medical Offices	710 Lawrence Expwy.
Santa Rosa	■ Santa Rosa Medical Center	401 Bicentennial Way
	● Santa Rosa Richard Stein Medical Offices	3925 Old Redwood Hwy. 3975 Old Redwood Hwy.
Selma	● Selma Medical Offices	2651 Highland Ave.
South San Francisco	■ South San Francisco Medical Center	1200 El Camino Real
Stinson Beach	○ Stinson Beach Medical Center	3419 State Route 1
Stockton	● Stockton Medical Offices	7373 West Lane
	□ Dameron Hospital ¹	525 W. Acacia St.
Tracy	● Tracy Medical Offices	2185 W. Grant Line Road
Turlock	□ Emanuel Medical Center ¹	825 Delbon Ave.
	○ Rodney Avilla, DO	2101 Geer Road
	○ Jagmohan Bhinder, MD	1860 Colorado Ave.
	○ Maryam Esho, MD	1729 N. Olive Ave.
	○ Nirbhai Hundal, MD	1516 Colorado Ave.
	○ Puliadi Kumar, MD	1110 Delbon Ave.
	○ Turlock Pediatric Medical Group	1100 Delbon Ave.
Union City	● Union City Medical Offices	3553 Whipple Road 3555 Whipple Road
	■ Vacaville Medical Center	1 Quality Drive
Vallejo	■ Vallejo Medical Center	975 Sereno Drive
Walnut Creek	■ Walnut Creek Medical Center	1425 S. Main St.
	● Park Shadelands Medical Offices	320 Lennon Lane

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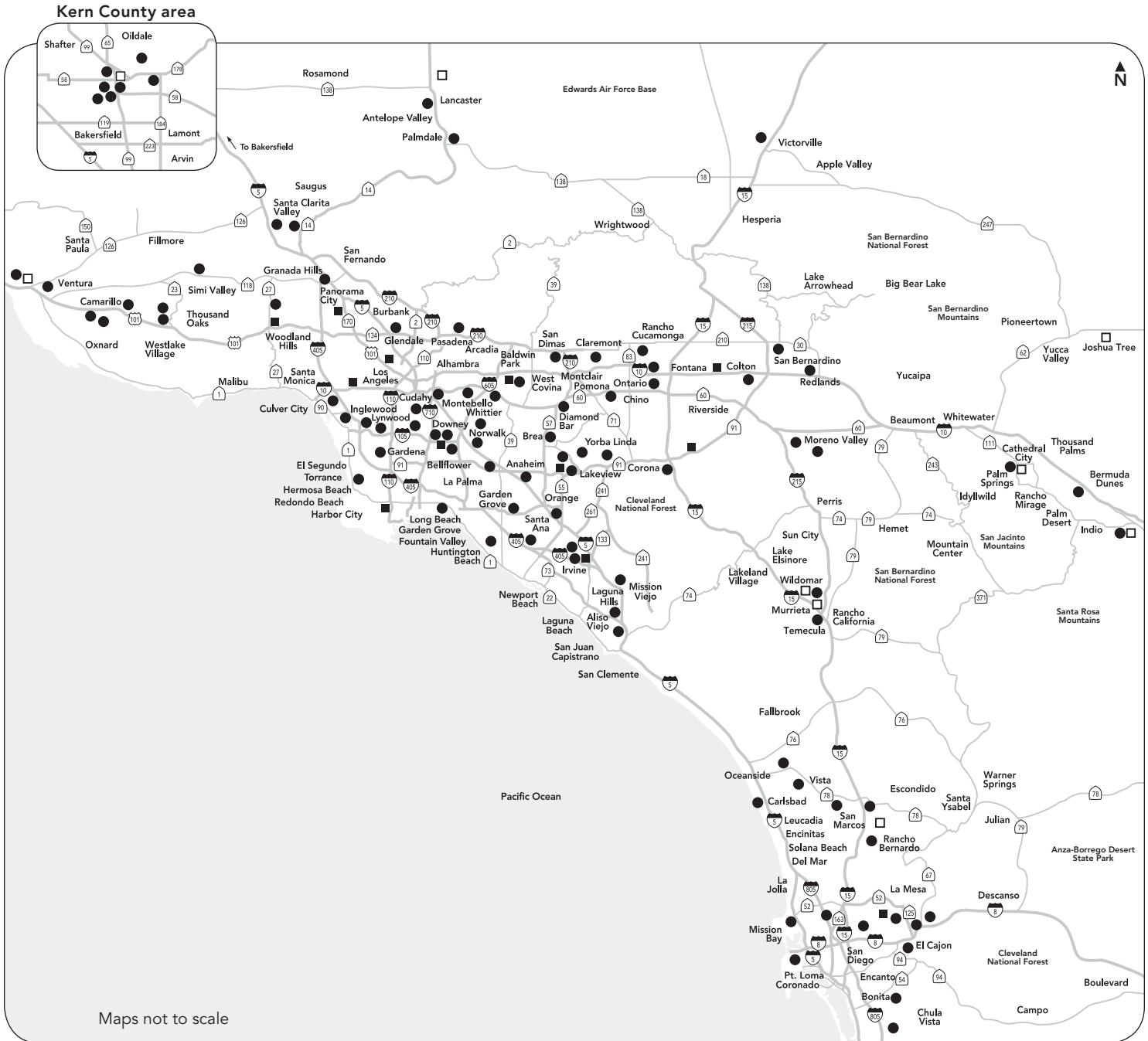
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¹Affiliated plan facilities provide selected inpatient and/or outpatient hospital and emergency services.

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SOUTHERN CALIFORNIA

The following information can help you find Kaiser Permanente and affiliated facilities in your community.



CITY	FACILITY	ADDRESS
Aliso Viejo	● Aliso Viejo Medical Offices	24502 Pacific Park Drive
Anaheim	■ Orange County–Anaheim Medical Center	441 N. Lakeview Ave.
	● Anaheim Hills Medical Offices	5475 E. La Palma Ave.
	● Anaheim Kraemer Medical Office Building 1	3460 E. La Palma Ave.
	● Euclid Medical Offices	1188 N. Euclid St.
	● Lakeview Medical Offices	411 N. Lakeview Ave.
Bakersfield	● Central Medical Offices	3733 San Dimas St.
	● Chester Avenue Medical Offices (Scheduled to open in fall 2010.)	2531 Chester Ave.
	● Coffee Road Medical Offices	4801 Coffee Road
	● Discovery Plaza Medical Offices	1200 Discovery Drive
	● East Hills Medical Offices	3700 Mall View Road
	● Ming Medical Offices	8800 Ming Ave.
	● Stockdale Medical Offices	3501 Stockdale Hwy.
	□ San Joaquin Community Hospital – Emergency services ¹	2615 Chester Ave.
Baldwin Park	■ Baldwin Park Medical Center	1011 Baldwin Park Blvd.
Bellflower	● Bellflower Medical Offices	9400 E. Rosecrans Ave.
Bonita	● Bonita Medical Offices	3955 Bonita Road
Brea	● Brea Medical Offices	1900 E. Lambert Road
Camarillo	● Buenaventura Camarillo Medical Offices	2620 E. Las Posas Road
Carlsbad	● Carlsbad Medical Offices	6860 Avenida Encinas
Chino	● Chino Medical Offices	11911 Central Ave.
City of Industry	● Crossroads Parkway Medical Offices	12801 Crossroads Pkwy. S.
Claremont	● Indian Hill Medical Offices	250 W. San Jose St.
Colton	● Colton Medical Offices	789 E. Cooley Drive
Corona	● Corona Medical Offices	2055 Kellogg Ave.
Cudahy	● Cudahy Medical Offices	7825 Atlantic Ave.
Culver City	● Playa Vista Medical Offices	5620 Mesmer Ave.
Diamond Bar	● Diamond Bar Medical Offices	1336 Bridgeway Drive
Downey	■ Downey Medical Center	9333 E. Imperial Hwy.
	● Garden Medical Offices	9353 E. Imperial Hwy.
	● Orchard Medical Offices	9449 E. Imperial Hwy.

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CITY	FACILITY	ADDRESS
El Cajon	● Bostonia Medical Offices	1630 E. Main St.
	● El Cajon Medical Offices	250 Travelodge Drive
Escondido	● Escondido Medical Offices	732 N. Broadway
	□ Palomar Medical Center – Emergency services ¹	555 E. Valley Pkwy.
Fontana	■ Fontana Medical Center	9961 Sierra Ave.
Garden Grove	● Garden Grove Medical Offices	12100 Euclid St.
Gardena	● Gardena Medical Offices	15446 S. Western Ave.
Glendale	● Glendale Medical Offices	444 W. Glenoaks Blvd.
Harbor City	■ South Bay Medical Center	25825 S. Vermont Ave.
Huntington Beach	● Huntington Beach Medical Offices	18081 Beach Blvd.
Indio	● Indio Medical Offices	81-719 Doctor Carreon Blvd.
	□ John F. Kennedy Memorial Hospital – Emergency services ¹	47111 Monroe St.
Inglewood	● Inglewood Medical Offices	110 N. La Brea Ave.
Irvine	■ Orange County–Irvine Medical Center	6640 Alton Pkwy.
	● Alton/Sand Canyon Medical Offices	6650 Alton Pkwy. 6670 Alton Pkwy.
Joshua Tree	● Barranca Medical Offices	6 Willard
	□ Hi-Desert Medical Center – Emergency services ¹	6601 White Feather Road
La Mesa	● La Mesa Medical Offices	8080 Parkway Drive
	● Rancho San Diego Medical Offices	3875 Avocado Blvd.
La Palma	● La Palma Medical Offices	5 Centerpointe Drive
Lancaster	● Lancaster Medical Offices	43112 N. 15th St. W.
	□ Antelope Valley Hospital – Emergency services ¹	1600 W. Avenue J
Long Beach	● Long Beach Medical Offices	3900 E. Pacific Coast Hwy.
Los Angeles	■ Los Angeles Medical Center	4867 Sunset Blvd.
	■ West Los Angeles Medical Center	6041 Cadillac Ave.
	● Culver Marina Medical Offices	12001 W. Washington Blvd.
	● East Los Angeles Medical Offices	5119 E. Pomona Blvd.
	● South Los Angeles Medical Offices (Scheduled to open in early 2011.)	1550 W. Manchester Ave.

CITY	FACILITY	ADDRESS
Lynwood	● Lynwood Medical Offices	3830 Martin Luther King Jr. Blvd.
Mission Hills	● Mission Hills Medical Offices	11001 Sepulveda Blvd.
Mission Viejo	● Mission Viejo Medical Offices	23781 Maquina Ave.
Montebello	● Montebello Medical Offices	1550 Town Center Drive
Moreno Valley	● Moreno Valley Community Hospital – Emergency services	27300 Iris Ave.
	● Moreno Valley Medical Offices	12815 Heacock St.
Murrieta	☐ Rancho Springs Medical Center	25500 Medical Center Drive
Norwalk	● Norwalk Medical Offices	12501 E. Imperial Hwy.
Oceanside	● Oceanside Medical Offices	3609 Ocean Ranch Blvd.
Ontario	● Ontario Vineyard Medical Offices	2295 S. Vineyard Ave.
Oxnard	● Buenaventura Oxnard Medical Offices	2200 E. Gonzales Road
	● Oxnard Medical Offices	2103 E. Gonzales Road
Palm Desert	● Palm Desert Medical Offices	75-036 Gerald Ford Drive
Palm Springs	● Palm Springs Medical Offices	1100 N. Palm Canyon Drive
	☐ Desert Regional Medical Center – Emergency services ¹	1150 N. Indian Canyon Drive
Palmdale	● Palmdale Medical Offices	4502 E. Ave. S
Panorama City	■ Panorama City Medical Center	13651 Willard St.
Pasadena	● Pasadena Medical Offices	3280 E. Foothill Blvd.
Rancho Cucamonga	● Rancho Cucamonga Medical Offices	10850 Arrow Route
Redlands	● Redlands Medical Offices	1301 California St.
Riverside	■ Riverside Medical Center	10800 Magnolia Ave.
San Bernardino	● San Bernardino Medical Offices	1717 Date Place
San Diego	■ San Diego Medical Center/ Kaiser Foundation Hospital	4647 Zion Ave.
	● Clairemont Mesa Medical Offices	7060 Clairemont Mesa Blvd.
	● Mission Bay Medical Offices	3033 Bunker Hill St.
	● Otay Mesa Outpatient Medical Center	4650 Palm Ave. 4660 Palm Ave.
	● Point Loma Medical Offices	3250 Fordham St. 3420 Kenyon St.
	● Rancho Bernardo Medical Offices	17140 Bernardo Center Drive
	● Vandever Medical Offices	4405 Vandever Ave.

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CITY	FACILITY	ADDRESS
San Dimas	● San Dimas Medical Offices	1255 W. Arrow Hwy.
San Juan Capistrano	● San Juan Capistrano Medical Offices	30400 Camino Capistrano
San Marcos	● San Marcos Outpatient Medical Center	400 Craven Road
Santa Ana	● Harbor–MacArthur Medical Offices	3401 S. Harbor Blvd.
	● Tustin–Santa Ana Medical Offices	1900 E. 4th St.
Santa Clarita	● Canyon Country Medical Offices	26415 Carl Boyer Drive
	● Santa Clarita Medical Offices	27107 Tourney Road
Simi Valley	● Simi Valley Medical Offices	3900 Alamo St.
Temecula	● Temecula Medical Offices	27309 Madison Ave.
Thousand Oaks	● Thousand Oaks I Medical Offices	365 E. Hillcrest Drive
	● Thousand Oaks II Medical Offices	145 Hodencamp Road
Torrance	● Torrance Medical Offices	20790 Madrona Ave.
Upland	● Upland Medical Offices	1183 E. Foothill Blvd.
Ventura	● Buenaventura Hill Road Medical Offices	888 S. Hill Road
	● Buenaventura Vista Medical Offices	2601 E. Main St.
	<input type="checkbox"/> Community Memorial Hospital of San Buenaventura – Emergency services ¹	147 N. Brent St.
Victorville	● High Desert Medical Offices	14011 Park Ave.
Vista	● Vista Medical Offices	780 Shadowridge Drive
West Covina	● West Covina Medical Offices	1249 Sunset Ave.
Whittier	● Whittier Medical Offices	12470 Whittier Blvd.
Wildomar	● Wildomar Medical Offices	36450 Inland Valley Drive
	<input type="checkbox"/> Inland Valley Medical Center	36485 Inland Valley Drive
Woodland Hills	■ Woodland Hills Medical Center	5601 De Soto Ave.
	● Erwin Street Medical Offices	21263 Erwin St.
Yorba Linda	● Yorba Linda Medical Offices	22550 E. Savi Ranch Pkwy.

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