

**MFOW WELFARE FUND**  
**240 2ND STREET**  
**SAN FRANCISCO CA 94105**

**AUGUST 2025**

**TO: ALL PLAN PARTICIPANTS COVERED UNDER THE PHS REPLACEMENT PROGRAM HMO AND PPO MEDICAL AND PRESCRIPTION DRUG PLANS**

**RE: IMPORTANT NOTICE REGARDING YOUR HEALTH CARE COVERAGE ANNUAL SUMMARY OF BENEFITS COVERAGE FORM**

Attached is a copy of the most recent Summary of Benefits Coverage Form outlining the Medical and Prescription Drug Plan benefits in which you are currently enrolled through the MFOW Welfare Benefit Plan and notices prepared by various providers highlighting some of the benefit changes for the year. The summary of changes outlined below, together with the enclosed Summary of Benefits Coverage Forms, constitute the “summary of material modifications” of the benefits provided under the medical plan options described in the Forms. Please keep this summary with your copy of the Summary Plan Description and your Evidence of Coverage.

If you wish to review the Summary of Benefits Coverage Forms for any of the other HMO/PPO plans and/or wish to make a change to one of the other HMO plans available to you, please contact the Welfare Fund Office (415) 986-1028 (240 Second Street, San Francisco, CA 94105). You have until September 30, 2025 to make any changes to your plan selection for an October 1, 2025 effective date. The following is a summary of the major Plan clarifications or changes (note that all benefits are subject to the terms of the plan document and applicable group insurance policy and Evidence of Coverage):

**Kaiser Northern and Southern California: Effective October 1, 2025, benefit changes and contract clarifications will be effective on the renewal date.**

1. Kaiser will implement coverage for doula services for pregnant women and develop a maternal and infant care services plan.
2. Coverage will be added for in vitro fertilization (IVF) in conjunction with Senate Bill 729. The Department of Managed Care is currently approving Kaiser’s proposed benefits but we have been advised that coverage will include the following services:
  - Services required to diagnose infertility, including laboratory and imaging services
  - Services to treat infertility, including medications, artificial insemination, and in vitro fertilization

Applicable cycle and/or benefit maximums are pending regulatory approval.

Members will have the same cost share for fertility services (such as imaging or lab tests) as they do when they receive those services for other conditions. Deductibles, copayments, and coinsurance for

fertility services will be applied to any out-of-pocket maximums for their benefit plan. Contact Member Services at [kp.org/supportcenter](http://kp.org/supportcenter) or 1-800-464-4000 if you have any questions.

3. Medications prescribed strictly for the purpose of weight loss are generally excluded with one exception. These medications will be covered in the case of an individual who is morbidly obese.

You should refer to your 2025 Benefit Booklet for a complete list of your plan benefits and coverage provisions.

#### **IMPORTANT NOTE TO KAISER EMPLOYEES RESIDING IN NORTHERN CALIFORNIA**

You will be receiving a new Kaiser identification card in the mail which you should begin using at Northern California facilities starting October 1, 2025. When you receive your new Kaiser ID card, please destroy your current Kaiser card as the group number for your medical plan has changed from 102126 to 608193. Your medical record number will not change, and your Kaiser benefits will remain the same. If you happen to be in Southern California and need care, you will be able to use your new ID card as a visiting member. Please contact the Welfare Fund Office if you have any questions.

**Kaiser Hawaii: Effective October 1, 2025,** there are no contract changes for the medical and drug plans however the following two clarifications apply:

1. ***Maternity care postpartum visits.*** Clarify that additional postpartum visits for maternity care are covered when medically necessary.
2. ***Physical, Occupational and Speech Therapy.*** Clarify that therapy services for developmental delay are covered when medically necessary.

For details on your coverage, please refer to your Kaiser Permanente Hawaii's Guide to Your Health Plan that can be obtained from the Plan Office or Kaiser.

Note: the Kaiser Hawaii Dental plan will be terminated October 1, 2025 and replaced with a Blue Shield PPO dental plan. Further details will follow in a separate notice to be mailed in September 2025.

**Kaiser Washington: Effective October 1, 2025, there are no substantial benefit changes nor contract clarifications effective on the renewal date.**

You should refer to your 2025 Benefit Booklet for a complete list of your plan benefits and coverage provisions.

**Kaiser – Oregon Plan: Effective October 1, 2025 there are no substantial benefit changes nor contract clarifications effective on the renewal date.**

You should refer to your 2025 Benefit Booklet for a complete list of your plan benefits and coverage provisions.

**Health Net HMO and PPO Plans:** There will be several plan changes effective October 1, 2025.

1. HealthNet will implement coverage for doula services for pregnant women and develop a maternal and infant care services plan.
2. Coverage will be added for in vitro fertilization (IVF) in conjunction with Senate Bill 729.
  - Services required to diagnose infertility, including laboratory and imaging services
  - Services to treat infertility, including medications, artificial insemination, and in vitro fertilization

Applicable cycle and/or benefit maximums are pending regulatory approval.

Members will have the same cost share for fertility services (such as imaging or lab tests) as they do when they receive those services for other conditions. Deductibles, copayments, and coinsurance for fertility services will be applied to any out-of-pocket maximums for their benefit plan.

### **Health Net PPO Plan Only**

1. Coverage for self-injectable drugs will be provided under the Pharmacy benefit. Currently members pay a 30% coinsurance under the medical plan; there will be the same 30% coinsurance but each fill will be limited to a \$250 maximum copayment.
2. The calendar year out-of-pocket maximum of \$2,000 per individual currently applies to medical expenses only. Effective with the October 1, 2025 renewal, prescription drug out-of-pocket expenses for covered drugs will be added to the \$2,000 maximum out of pocket amount.

You should refer to your 2025 Benefit Booklet for a complete list of your plan benefits and coverage provisions.

### **Grandfathered Group Health Plans**

The MFWO Welfare Fund's Board of Trustees has concluded that the HMOs are "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). The HealthNet PPO plan, however, is a non-grandfathered plan. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of certain lifetime limits on benefits.

Although it is a "grandfathered health plan", you should know that the Plan provides health coverage/benefits beyond the "basic" level of benefits and has long maintained many consumer protections now required under the Affordable Care Act. For example, the Plan has always prohibited rescissions of coverage due to a member's health condition as well as exclusions for pre-existing conditions for children and adults. There is also no "waiting period" for benefit eligibility once a member attains initial coverage based on required work hours. Nor does the Plan discriminate in favor of certain members based on compensation, age, gender, or health status.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at (415) 986-1028. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

## Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services

Coverage Period: 10/01/2025-09/30/2026



KAISER PERMANENTE® : Mfow Welfare Fund – MFOW Welfare Fund - \$0 Trad

Coverage for: Individual / Family | Plan Type: EPO

All [plans](#) offered and underwritten by Kaiser Foundation Health Plan of the Northwest



The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately.

This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage see [www.kp.org/plandocuments](http://www.kp.org/plandocuments) or call 1-800-813-2000 (TTY: 711). For definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at <http://www.healthcare.gov/sbc-glossary> or call 1-800-813-2000 (TTY: 711) to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	\$0	See the Common Medical Events chart below for your costs for services this <a href="#">plan</a> covers.
Are there services covered before you meet your <a href="#">deductible</a> ?	Not applicable.	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply.
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	\$600 Individual / \$1,200 Family	The <a href="#">out-of-pocket</a> limit is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket</a> limit has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , health care this <a href="#">plan</a> doesn't cover, and services indicated in chart starting on page 2.	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. See <a href="http://www.kp.org">www.kp.org</a> or call 1-800-813-2000 (TTY: 711) for a list of participating <a href="#">providers</a> .	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes, but you may self-refer to certain <a href="#">specialists</a> .	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .



All [copayment](#) and [coinsurance](#) costs shown in this chart are after your [deductible](#) has been met, if a [deductible](#) applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$10 / visit	Not covered	\$5 / visit for the first 3 outpatient visits combined for primary care, mental/behavioral health, substance abuse services, and other qualified visits.
	<a href="#">Specialist</a> visit	\$10 / visit	Not covered	None
	<a href="#">Preventive care/screening/immunization</a>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <a href="#">provider</a> if the services needed are preventive. Then check what your <a href="#">plan</a> will pay for.
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	X-ray: No charge Lab tests: No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	Some services may require prior authorization.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.kp.org/formulary">www.kp.org/formulary</a>	Generic drugs	\$10 (retail); \$20 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines. Does not apply to the <a href="#">out-of-pocket</a> limit.
	Preferred brand drugs	\$10 (retail); \$20 (mail order) / prescription	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Subject to <a href="#">formulary</a> guidelines. Does not apply to the <a href="#">out-of-pocket</a> limit.
	Non-preferred brand drugs	Applicable Generic or Preferred brand drug cost shares apply.	Not covered	Up to a 30-day supply (retail); up to a 90-day supply (mail order). Does not apply to the <a href="#">out-of-pocket</a> limit. Covered only when you meet <a href="#">formulary</a> exception criteria.
	<a href="#">Specialty drugs</a>	Applicable Generic or Preferred brand drug cost shares apply.	Not covered	Up to a 30-day supply (retail). Subject to <a href="#">formulary</a> guidelines, when approved through exception process.
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	\$10 / visit	Not covered	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	Physician/surgeon fees	No charge	Not covered	Physician/surgeon fees are included in the Facility fee.
If you need immediate medical attention	<a href="#">Emergency room care</a>	\$75 / visit	\$75 / visit	<a href="#">Copayment</a> waived if admitted directly to the hospital as an inpatient.
	<a href="#">Emergency medical transportation</a>	\$75 / trip	\$75 / trip	None
	<a href="#">Urgent care</a>	\$20 / visit	Not covered	Non-Participating Providers covered when temporarily outside the service area: \$20 / visit
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	Prior authorization required.
	Physician/surgeon fees	No charge	Not covered	Prior authorization required.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$10 / visit	Not covered	\$5 / visit for the first 3 outpatient visits combined for primary care, mental/behavioral health, substance abuse services, and other qualified visits.
	Inpatient services	No charge	Not covered	Prior authorization required.
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for <a href="#">preventive services</a> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	Not covered	None
If you need help recovering or have other special needs	<a href="#">Home health care</a>	No charge	Not covered	130 visit limit / year. Prior authorization required.
	<a href="#">Rehabilitation services</a>	Outpatient: \$10 / visit Inpatient: No charge	Not covered	Outpatient: 20 visit limit / therapy / year. Prior authorization required. Inpatient: Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Participating Provider (You will pay the least)	Non-Participating Provider (You will pay the most)	
	<a href="#">Habilitation services</a>	\$10 / visit	Not covered	20 visit limit / therapy / year. Prior authorization required.
	<a href="#">Skilled nursing care</a>	No charge	Not covered	100 day limit / year. Prior authorization required.
	<a href="#">Durable medical equipment</a>	No charge	Not covered	Subject to <a href="#">formulary</a> guidelines. Prior authorization required.
	<a href="#">Hospice services</a>	No charge	Not covered	Prior authorization required.
If your child needs dental or eye care	Children's eye exam	\$10 / visit for refractive exam	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental checkups	Not covered	Not covered	None

### Excluded Services & Other Covered Services

Services Your <a href="#">Plan</a> Generally Does NOT Cover (Check your policy or <a href="#">plan</a> document for more information and a list of any other <a href="#">excluded services</a> .)			
<ul style="list-style-type: none"> <li>Children's glasses</li> <li>Cosmetic surgery</li> <li>Dental care (Adult and Child)</li> </ul>	<ul style="list-style-type: none"> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S</li> <li>Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine foot care</li> <li>Weight loss programs</li> </ul>	
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your <a href="#">plan</a> document.)			
<ul style="list-style-type: none"> <li>Acupuncture (physician referred)</li> <li>Bariatric surgery</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care (physician referred)</li> <li>Hearing aids (Under age 26: 1 aid / ear, every 36 months)</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Routine eye care (Adult)</li> </ul>	

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is shown in the chart below. Other coverage options may be available to you, too, including buying individual insurance coverage through the [Health Insurance Marketplace](#). For more information about the [Marketplace](#), visit [www.HealthCare.gov](http://www.HealthCare.gov) or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide



complete information on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact the agencies in the chart below.

**Contact Information for Your Rights to Continue Coverage & Your Grievance and Appeals Rights:**

Kaiser Permanente Member Services	1-800-813-2000 (TTY: 711) or <a href="http://www.kp.org/memberservices">www.kp.org/memberservices</a>
Department of Labor's Employee Benefits Security Administration	1-866-444-EBSA (3272) or <a href="http://www.dol.gov/ebsa/healthreform">www.dol.gov/ebsa/healthreform</a>
Department of Health & Human Services, Center for Consumer Information & Insurance Oversight	1-877-267-2323 x61565 or <a href="http://www.cciio.cms.gov">www.cciio.cms.gov</a>
Oregon Division of Financial Regulation	1-888-877-4894 or <a href="http://www.dfr.oregon.gov">www.dfr.oregon.gov</a>
Washington Department of Insurance	1-800- 562- 6900 or <a href="http://www.insurance.wa.gov">www.insurance.wa.gov</a>

**Does this [plan](#) provide Minimum Essential Coverage? Yes**

[Minimum Essential Coverage](#) generally includes [plans](#), [Health Insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#) you may not be eligible for the [premium tax credit](#).

**Does this [plan](#) meet the Minimum Value Standards? Yes**

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

**Language Access Services:**

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-813-2000 (TTY: 711).

Traditional Chinese (中文): 如果需要中文的幫助, 請撥打這個號碼 1-800-813-2000 (TTY: 711).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-813-2000 (TTY: 711).

Pennsylvania Dutch (Deutsch): Fer Hilf griegie in Deutsch, ruf 1-800-813-2000 (TTY: 711) uff.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-813-2000 (TTY: 711).

Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 1-800-813-2000 (TTY: 711).

Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-813-2000 (TTY: 711).

Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang 1-800-813-2000 (TTY: 711).

*To see examples of how this [plan](#) might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:



**This is not a cost estimator.** Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$10
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other (blood work) <a href="#">copayment</a>	\$0

This EXAMPLE event includes services like:

[Specialist](#) office visits (*prenatal care*)  
 Childbirth/Delivery Professional Services  
 Childbirth/Delivery Facility Services  
[Diagnostic tests](#) (*ultrasounds and blood work*)  
[Specialist](#) visit (*anesthesia*)

<b>Total Example Cost</b>	<b>\$12,700</b>
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In this example, Peg would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$10
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$60
<b>The total Peg would pay is</b>	<b>\$70</b>

### Managing Joe's Type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$10
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other (blood work) <a href="#">copayment</a>	\$0

This EXAMPLE event includes services like:

[Primary care physician](#) office visits (*including disease education*)  
[Diagnostic tests](#) (*blood work*)  
[Prescription drugs](#)  
[Durable medical equipment](#) (*glucose meter*)

<b>Total Example Cost</b>	<b>\$5,600</b>
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In this example, Joe would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$500
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Joe would pay is</b>	<b>\$500</b>

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$0
■ <a href="#">Specialist copayment</a>	\$10
■ Hospital (facility) <a href="#">copayment</a>	\$0
■ Other (x-ray) <a href="#">copayment</a>	\$0

This EXAMPLE event includes services like:

[Emergency room care](#) (*including medical supplies*)  
[Diagnostic test](#) (*x-ray*)  
[Durable medical equipment](#) (*crutches*)  
[Rehabilitation services](#) (*physical therapy*)

<b>Total Example Cost</b>	<b>\$2,800</b>
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In this example, Mia would pay:

Cost Sharing	
<a href="#">Deductibles</a>	\$0
<a href="#">Copayments</a>	\$200
<a href="#">Coinsurance</a>	\$0
What isn't covered	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$200</b>

## **Nondiscrimination Notice**

Kaiser Foundation Health Plan of the Northwest (Kaiser Health Plan) complies with applicable federal and state civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. Kaiser Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex, gender identity, or sexual orientation. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats, such as large print, audio, and accessible electronic formats
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call Member Services at **1-800-813-2000** (TTY: **711**).

If you believe that Kaiser Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sex, gender identity, or sexual orientation, you can file a grievance with our Civil Rights Coordinator, by mail, phone, or fax. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You may contact our Civil Rights Coordinator at: Member Relations Department, Attention: Kaiser Civil Rights Coordinator, 500 NE Multnomah St. Ste 100, Portland, OR 97232-2099, Phone: **1-800-813-2000** (TTY: **711**), Fax: **1-855-347-7239**.

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

### **For Washington Members**

You can also file a complaint with the Washington State Office of the Insurance Commissioner, electronically through the Office of the Insurance Commissioner Complaint portal, available at <https://www.insurance.wa.gov/file-complaint-or-check-your-complaint-status>, or by phone at 1-800-562-6900, or 360-586-0241 (TDD). Complaint forms are available at <https://fortress.wa.gov/oic/onlineServices/cc/pub/complaintinformation.aspx>.